Filing at a Glance

Company:	Coventry Health and Life Insurance Co.
Product Name:	TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs
State:	Tennessee
TOI:	H16I Individual Health - Major Medical
Sub-TOI:	H16I.005A Individual - Preferred Provider (PPO)
Filing Type:	Form/Rate
Date Submitted:	04/30/2013
SERFF Tr Num:	CVLA-128995176
SERFF Status:	Assigned
State Tr Num:	H-130560
State Status:	Assigned - Pending Review
Co Tr Num:	042013 - 01
Implementation Date Requested:	On Approval
Author(s):	Nancy Bourgeois
Reviewer(s):	Vicky Stotzer (primary), Brian Hoffmeister, Melissa Merritt
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:
I HIX P
TN CHL EXCH. Cov1 HPN PPO
individual exchange catastrophic, bronze, silver & gold
Memphis

State: Tennessee **Filing Company:** Coventry Health and Life Insurance Co.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs
Project Name/Number: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01

General Information

Project Name: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs
Project Number: 04192013 - 01
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Nancy Bourgeois

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 05/01/2013
State Status Changed: 05/01/2013
Created By: Nancy Bourgeois
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null
Exchange Intentions:

This product is also being submitted via HIOS and SERFF Plan Management.

Filing Description:
Dear Ms. Stotzer,

I am writing on behalf of Coventry Health and Life Insurance Company to seek approval for the following new TN CHL EXCHANGE Individual Carelink from Coventry PPO documents to be used on Tennessee's Health Insurance Marketplace:

TN CHL EXCH. Cov1 HPN PPO Certificate of Coverage-- TN CHL ON-EXCH. Cov1 HPN PPO -COC -01.2014;
TN CHL EXCH. Cov1 HPN PPO Certificate of Coverage (Catastrophic) -- TN CHL ON-EXCH. Cov1 HPN PPO –COC.Cat. -01.2014;
TN CHL EXCH. Cov1 HPN PPO SOB (Gold)-- TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold -01.2014
TN CHL EXCH. Cov1 HPN PPO SOB (Gold Indian No Cost Share)-- TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.NCS -01.2014
TN CHL EXCH. Cov1 HPN PPO SOB (Gold Indian Provider No Cost)-- TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.Pr.NC -01.2014
TN CHL EXCH. Cov1 HPN PPO SOB (Silver)-- TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver -01.2014
TN CHL EXCH. Cov1 HPN PPO SOB (Silver Indian No Cost Share)-- TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver.Ind.NCS -01.2014
TN CHL EXCH. Cov1 HPN PPO SOB (Silver Indian Provider No Cost)-- TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver.Ind.Pr.NC -01.2014
TN CHL EXCH. Cov1 HPN PPO SOB (Silver 1)-- TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 1 -01.2014
TN CHL EXCH. Cov1 HPN PPO SOB (Silver 2)-- TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 2 -01.2014
TN CHL EXCH. Cov1 HPN PPO SOB (Silver 3)-- TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 3 -01.2014
TN CHL EXCH. Cov1 HPN PPO SOB (Bronze)-- TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze -01.2014
TN CHL EXCH. Cov1 HPN PPO SOB (Bronze Indian No Cost Share)-- TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.NCS -01.2014
TN CHL EXCH. Cov1 HPN PPO SOB (Bronze Indian Provider No Cost)-- TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.Pr.NC -01.2014
TN CHL EXCH. Cov1 HPN PPO SOB (2nd Bronze)-- TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze -01.2014
TN CHL EXCH. Cov1 HPN PPO SOB (2nd Bronze Indian No Cost Share)-- TN CHL ON-EXCH. Cov1 HPN PPO

State: *Tennessee* ***Filing Company:*** *Coventry Health and Life Insurance Co.*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*
Product Name: *TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs*
Project Name/Number: *TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01*

–SOB.2nd.Bronze.Ind.NCS -01.2014
TN CHL EXCH. Cov1 HPN PPO SOB (2nd Bronze Indian Provider No Cost)-- TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze.Ind.Pr.NC -01.2014
TN CHL EXCH. Cov1 HPN PPO SOB (Catastropic)-- TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Cat. -01.2014

Please see the Statement of Variability provided under the Supporting Documentation tab.

Rate information has been provided under the Rate/Rules tab.

Our Tennessee NAIC # is 81973.

Please do not hesitate to contact me with any issues or questions.

Best regards,
Nancy G. Bourgeois
Tel. (504) 834-0840 Ext. 503-2138

Company and Contact

Filing Contact Information

Nancy Bourgeois, Regulatory Compliance Documents Coordinator
3838 N. Causeway Blvd.
Suite 3350
Metairie, LA 70002

ngbourgeois@cvty.com

504-834-0840 [Phone] 2138 [Ext]

Filing Company Information

Coventry Health and Life Insurance Co.
5350 Poplar Ave.
Suite 390
Memphis, TN 38119
(901) 462-2380 ext. [Phone]

CoCode: 81973
Group Code:
Group Name:
FEIN Number: 75-1296086

State of Domicile: Delaware
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$900.00
Retaliatory?	Yes
Fee Explanation:	Eighteen (18) forms x $50.00 = $900.00. Delaware is our domicile state, and the fee is $50.00 per form.

Check Number	Check Amount	Check Date
2356	$850.00	04/26/2013
2355	$50.00	04/26/2013

SERFF Tracking #:	*CVLA-128995176*	***State Tracking #:***	*H-130560*	***Company Tracking #:***	*042013 - 01*

State:	*Tennessee*	***Filing Company:***	*Coventry Health and Life Insurance Co.*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs*		
Project Name/Number:	*TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01*		

Form Schedule

Lead Form Number: TN CHL ON-EXCH. Cov1 HPN PPO -COC -01.2014

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		TN CHL EXCH. Cov1 HPN PPO Certificate of Coverage	TN CHL ON-EXCH. Cov1 HPN PPO -COC -01.2014	CER	Initial			4.29.13 - 9.CLdef.-Pe.RL.-CLpg.fm.ACC.CHG.-RECD.TH.-defbr-ACC CHG-TN ON-EX Cov1 COC.pdf
2		TN CHL EXCH. Cov1 HPN PPO SOB (Gold)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold -01.2014	SCH	Initial			4.30.13 - recd.fr.Erin - Gold TN BAPTIST HPN OON 2 Tier Sch.Cov.Serv.Ben.pdf
3		TN CHL EXCH. Cov1 HPN PPO SOB (Gold Indian No Cost Share)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.NCS -01.2014	SCH	Initial			4.29.13 - recd.fr.Erin - Gold TN BAPTIST HPN OON 2 Tier Indian NCS.pdf

SERFF Tracking #: CVLA-128995176 **State Tracking #:** H-130560 **Company Tracking #:** 042013 - 01

State: Tennessee **Filing Company:** Coventry Health and Life Insurance Co.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs
Project Name/Number: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01

Lead Form Number: TN CHL ON-EXCH. Cov1 HPN PPO -COC -01.2014

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
4		TN CHL EXCH. Cov1 HPN PPO SOB (Gold Indian Provider No Cost)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.Pr.NC - 01.2014	SCH	Initial			4.29.13 - fr.SHARE DR.- Gold TN BAPTIST HPN OON 2 Tier Ind.Pr.NC Sch.Cov.Serv.Ben.pdf
5		TN CHL EXCH. Cov1 HPN PPO SOB (Silver)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver -01.2014	SCH	Initial			4.29.13 - fr.SHARE DR.- Silver Basic TN BAPTIST HPN OON 2 Tier Sch.Cov.Serv.Ben.pdf
6		TN CHL EXCH. Cov1 HPN PPO SOB (Silver Indian No Cost Share)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver.Ind.NCS - 01.2014	SCH	Initial			4.29.13 - recd.fr.Erin - Basic Silver TN BAPTIST HPN OON 2 Tier Indian NCS.pdf

State: Tennessee **Filing Company:** Coventry Health and Life Insurance Co.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs
Project Name/Number: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01

Lead Form Number: TN CHL ON-EXCH. Cov1 HPN PPO -COC -01.2014

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
7		TN CHL EXCH. Cov1 HPN PPO SOB (Silver Indian Provider No Cost)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver .Ind.Pr.NC -01.2014	SCH	Initial			4.29.13 - fr.SHARE DR.- Silver Basic TN BAPTIST HPN OON 2 Tier Ind.Pr.NC Sch.Cov.Serv.Ben. pdf
8		TN CHL EXCH. Cov1 HPN PPO SOB (Silver 1)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 1 -01.2014	SCH	Initial			4.29.13 - fr.SHARE DR.- Silver 1 TN BAPTIST HPN OON 2 Tier Sch.Cov.Serv.Ben. pdf
9		TN CHL EXCH. Cov1 HPN PPO SOB (Silver 2)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 2 -01.2014	SCH	Initial			4.29.13 - fr.SHARE DR.- Silver 2 TN BAPTIST HPN OON 2 Tier Sch.Cov.Serv.Ben. pdf

SERFF Tracking #: CVLA-128995176 **State Tracking #:** H-130560 **Company Tracking #:** 042013 - 01

State: Tennessee **Filing Company:** Coventry Health and Life Insurance Co.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs
Project Name/Number: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01

Lead Form Number: TN CHL ON-EXCH. Cov1 HPN PPO -COC -01.2014

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
10		TN CHL EXCH. Cov1 HPN PPO SOB (Silver 3)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 3 -01.2014	SCH	Initial			4.29.13 - fr.SHARE DR.- Silver 3 TN BAPTIST HPN OON 2 Tier Sch.Cov.Serv.Ben. pdf
11		TN CHL EXCH. Cov1 HPN PPO SOB (Bronze)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze -01.2014	SCH	Initial			4.29.13 - fr.SHARE DR.- Bronze TN BAPTIST HPN OON 2 Tier Sch. of Cov.Serv.Ben.pdf
12		TN CHL EXCH. Cov1 HPN PPO SOB (Bronze Indian No Cost Share)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.NCS - 01.2014	SCH	Initial			4.29.13 - recd.2 fr.Erin - Bronze TN BAPTIST HPN OON 2 Tier Indian NCS.pdf

State: Tennessee **Filing Company:** Coventry Health and Life Insurance Co.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs
Project Name/Number: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01

Lead Form Number: TN CHL ON-EXCH. Cov1 HPN PPO -COC -01.2014

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
13		TN CHL EXCH. Cov1 HPN PPO SOB (Bronze Indian Provider No Cost)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.Pr.NC -01.2014	SCH	Initial			4.29.13 - fr.SHARE DR.- Bronze TN BAPTIST HPN OON 2 Tier Ind.Pr.NC Sch.Cov.Serv.Ben.pdf
14		TN CHL EXCH. Cov1 HPN PPO SOB (2nd Bronze)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze - 01.2014	SCH	Initial			4.29.13 - fr.SHARE DR.- 2nd Bronze TN BAPTIST HPN OON 2 Tier Sch.Cov.Serv.Ben.pdf
15		TN CHL EXCH. Cov1 HPN PPO SOB (2nd Bronze Indian No Cost Share)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze.Ind.NCS -01.2014	SCH	Initial			4.29.13 - fr.SHARE DR.- 2nd Bronze TN BAPTIST HPN OON 2 Tier Indian NCS.pdf

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State:	*Tennessee*	***Filing Company:***	*Coventry Health and Life Insurance Co.*
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Product Name:	*TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs*		
Project Name/Number:	*TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01*		

Lead Form Number: TN CHL ON-EXCH. Cov1 HPN PPO -COC -01.2014

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
16		TN CHL EXCH. Cov1 HPN PPO SOB (2nd Bronze Indian Provider No Cost)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze.Ind.Pr.NC - 01.2014	SCH	Initial			4.29.13 - fr.SHARE DR.- 2nd Bronze TN BAPTIST HPN OON 2 Tier Ind.Pr.NC Sch.Cov.Serv.Ben.pdf
17		TN CHL EXCH. Cov1 HPN PPO SOB (Catastropic)	TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Cat. - 01.2014	SCH	Initial			4.29.13 - fr.SHARE DR.- Catastrophic TN BAPTIST HPN OON 2 Tier Sch.Cov.Serv.Ben.pdf
18		TN CHL EXCH. Cov1 HPN PPO Certificate of Coverage (Catastrophic)	TN CHL ON-EXCH. Cov1 HPN PPO –COC.Cat. - 01.2014	CER	Initial			4.29.13 - 9.CL.def.-.Pe.CL.-CL.ACC.CHG.fm.pg.-rev.cat.ft.-RECD.TH.Cat.-ACC CHG - TN ON-EX Cov1 COC.Cat.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form

State: Tennessee **Filing Company:** Coventry Health and Life Insurance Co.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs
Project Name/Number: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01

CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

COVENTRY HEALTH AND LIFE INSURANCE COMPANY

Carelink from Coventry

PREFERRED PROVIDER ORGANIZATION ("PPO")

INDIVIDUAL MEMBER CONTRACT AVAILABLE IN THE HEALTH INSURANCE MARKETPLACE

Under this PPO Plan, inpatient, outpatient and other Covered Services are available through both In-Network (Participating) Providers and Out-of-Network (Non-Participating) Providers. Benefits under this Plan are subject to Our Utilization Management Program.

Keep in mind that using a Participating Provider (Your In-Network benefits) will usually cost You less than using a Non-Participating Provider (Your Out-of-Network benefits) because Participating Providers are Contracted with Us to provide health care services to Members for a lower fee, whereas Non-Participating Providers are not Contracted with Us. Please see Section 1 for more information on how Your In-Network and Out-of-Network benefits work.

Dear New Member:

Welcome to Coventry Health and Life Insurance Company! We are extremely pleased that You have enrolled in Our Carelink from Coventry Plan and look forward to serving You.

Coventry is a subsidiary of Coventry Health Care, Inc., a Fortune 500 company operating Plans, insurance companies, Network rental, and workers' compensation services companies in all 50 states and Puerto Rico. We are one of the country's largest managed health care companies providing a full range of risk and fee-based health care products and services.

Coventry Health Care's Plans emphasize wellness and preventive care. You will find that Our strong Network of area Physicians, Hospitals, and other Providers offers a broad range of services to meet Your medical needs.

As a Coventry Health Care Member, it is important that You understand the way Your Plan operates. This Individual Member Contract is an important legal document and contains the information You need to know about Your Coverage with Us and how to get the care You need. Please keep it in a safe place where You can refer to it as needed.

Please take a few minutes to read these materials and to make Your Covered family Members aware of the provisions of Your Coverage. Our Customer Services Department is available to answer any questions You may have about Your Coverage. You can reach them at **855-449-2889** Monday through Friday, [8:00 a.m. to 6:00 p.m. ET.] You may also access Your benefit information 24 hours a day, seven days a week by registering and logging in at www.chctn.com.

We look forward to serving You and Your family.

Yours very truly,

J Pegues
Chief Executive Officer
Coventry Health and Life Insurance Company, Inc.

COVENTRY HEALTH AND LIFE INSURANCE COMPANY.
INDIVIDUAL MEMBER CONTRACT AVAILABLE IN THE HEALTH INSURANCE MARKET PLACE

The individual Contract (hereinafter referred to as the "Contract") between Coventry Health and Life Insurance Company. (hereafter referred to as the "Health Plan", "CHL", "We", "Us", or "Our") and You is made up of the following documents:

- Individual Member Contract and any Contract amendments;
- Schedule of Benefits; and
- Applicable Riders

This is to certify that, in consideration for and upon payment of the Premium rate, the individual(s) Covered under this Contract are entitled to the benefits set forth under the terms and conditions in this Contract. The laws of the State of Tennessee govern this Contract. This Contract is a legal document. The Covered Services and provisions described in this Contract are effective only while You are eligible for Coverage under the Contract and while the Contract is in effect. You may enroll and remain enrolled under the Contract if You meet the eligibility requirements described in Section 2 of this Individual Member Contract. This Contract is renewable and may only be non-renewed and/or terminated) as set forth in Section 3. You are subject to all terms, conditions, limitations, and Exclusions in this Contract and to all of the rules and regulations of the Health Plan. By paying Premiums or having Premiums paid on Your behalf, You accept the provisions of this Contract.

This Contract gives You access to both In-Network benefits, provided by Participating Providers, and Out-of-Network benefits, provided by Non-Participating Providers. Keep in mind that using Out-of-Network Benefits may cost You more than using In-Network benefits. Please read Section 1 to learn more about how Your In-Network and Out-of-Network benefits work, or call Our Customer Service Department at 855-449-2889 if You have any questions.

THIS CONTRACT SHOULD BE READ AND RE-READ IN ITS ENTIRETY

Many of the provisions of this Contract are interrelated. Therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Contract have special meanings. These words will appear capitalized and are defined for You in Section 12. By using these definitions, You will have a clearer understanding of Your Coverage. From time to time, the Contract may be amended, as required by and in accordance with state and federal law. When this occurs, We will provide an Amendment or new Contract to You. You should keep this document in a safe place for Your future reference.

HEALTH CARE REFORM

Coventry Health and Life Insurance Company are in compliance with PPACA. If any provision of PPACA conflicts with any of the provisions of this Contract, the Contract will be interpreted to be compliant with PPACA.

COVENTRY HEALTH AND LIFE INSURANCE COMPANY
5350 Poplar Ave, Suite 390
Memphis, Tennessee 38119
855-449-2889

SPECIAL NOTICES

NOTICE TO QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN MEMBERS (HSA NOTICE)

If You enrolled in a qualified High Deductible Health Plan ("HDHP") that is HSA-compatible, please read this important notice:

The Coventry Health and Life Insurance Company. High Deductible Plan is designed to be a Federally qualified High Deductible Health Plan compatible with Health Savings Accounts ("HSA's"). Enrollment in an HDHP that is HSA-compatible is only one of the eligibility requirements for establishing and contributing to an HSA.

Please note that if You have other health Coverage in addition to the Coverage under this Contract, in most instances You may not be eligible to establish or contribute to an HSA, unless both Coverages qualify as High Deductible Health Plans.

Coventry Health and Life Insurance Company does not provide tax advice. The Tennessee Department of Insurance does NOT in any way warrant that this Plan meets the federal requirements.

Please consult with Your financial or legal advisor for information about Your eligibility for an HSA.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health Plans and Health Insurance issuers offering group Health Insurance Coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending Provider (e.g., Your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, Plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan or issuer may not, under federal law, require that You, Your Physician, or other health care Provider obtain Authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, You may be required to obtain precertification for any days of confinement that exceeds 48 hours (or 96 hours). For information on precertification, contact Your Plan administrator.

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under this Health Plan, Coverage will be provided to a person who is receiving benefits for a Medically Necessary mastectomy and who elects breast reconstruction after the mastectomy for:

(1) reconstruction of the breast on which a mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) prostheses; and

(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This Coverage will be provided in consultation with the attending Physician and the patient, and will be subject to the same annual Deductibles and Coinsurance provisions that apply for the mastectomy. If You have any questions about our Coverage of mastectomies and Reconstructive Surgery, please contact the Member Services number on Your ID card.

TABLE OF CONTENTS

SECTION 1
USING YOUR BENEFITS

Carelink from Coventry ("Carelink") is designed as a new model for delivering quality care health care services to You while keeping Your costs down. This Contract provides You with an exclusive Network of providers that includes the Carelink [Hospital Partner] Network of Participating Providers and those Specialist Participating Providers Participating in the Carelink [Hospital Partner] product. The Carelink [Hospital Partner] will have in place: a sufficient number of Primary Care Physicians who will assist You in coordinating Your care so that there is less duplication of services; leadership and management structures, including clinical and administrative systems; and processes to promote evidence-based medicine and patient engagement, report on quality and cost measures and coordinate care, such as through the use of telemedicine, remote patient monitoring and other enabling technologies. Our Participating Provider Network (hereafter referred to as the "Network") may change from time to time. Please visit Our website at http://tn.coventryproviders.com/, or You may call Our Customer Service Department at 855-449-2889 in order to find out if a Provider is a Participating Provider.

If a Provider does not have a Contractual agreement with Us, the Provider is considered to be a Non-Participating Provider.

Keep in mind that using a Participating Provider (Your In-Network benefits) may cost You less than using a Non-Participating Provider (Your Out-of-Network benefits). If services are provided to You by a Non-Participating Provider, those services will be paid at the Out-of-Network level using the Out-of-Network Rate ("ONR"). Please see Section 1.7.2 for more information on Out-of-Network Providers and the ONR.

If You receive Covered Services at an In-Network Hospital or outpatient Facility, You might inadvertently receive some services from Non-Participating Providers. In this instance, We will pay the In-Network level for Covered Services provided by a Non-Participating Pathologist, Anesthesiologist, Radiologist, Lab or Emergency Room Physician.

1.1 Membership Identification (ID) Card.

Every Plan Member receives a Membership ID card. Please carry Your Member ID card with You at all times, and present it before health care services are rendered. If Your Member ID card is missing, lost, or stolen, contact Our Customer Service Department at **855-449-2889** or visit Our website at www.chctn.com to order a replacement.

1.2 Your Primary Care Physician (PCP).

You must choose a PCP for Yourself and each Member of Your family. You may select Your PCP by calling the Customer Service phone number located on Your ID card or by visiting Our website at http://member.cvty.com,You have the right to designate any Primary Care Provider, who participates in Our Network and is available to accept You or Your family Members. If applicable to Your Plan, the name and phone number of the PCP You select will be listed on Your Member ID card.

The role of the PCP is important to the coordination of Your care, and You are encouraged to contact Your PCP when medical care is needed. This may include preventive health services, consultation with Specialists and other Providers, Emergency Services, and Urgent Care.

You can select a PCP from one of the following specialties: Family Practice, Internal Medicine, General Practice, OB/GYN, or Pediatrics. You may choose one PCP for the entire family, or each Dependent may select a different PCP. To locate the most current Directory of Health Care Providers, please visit Our website at http://tn.coventryproviders.com/. Our online Provider Directory is updated at least monthly.

If a PCP is required per Your Plan documents, and You wish to change Your PCP, You must contact Our Customer Service Department at **855-449-2889**. You may also visit Our website at

http://member.cvty.com, to make this change.

1.3 Prior Authorizations and Utilization Management.

You must comply with all of the Utilization Management Program policies and procedures noted in this Section. Our Utilization Management Program is designed to help You receive Medically Necessary Health Care in a timely manner and at the most reasonable cost. It is an effective measure in helping to monitor the quality and cost-effectiveness of Your health care.

Our Utilization Management nurses review requests for non-emergent Hospital admissions, outpatient surgeries, and other outpatient procedures. Our nurses also monitor the care You receive during a Hospital stay and post discharge.

General Policies. The following policies apply to both In-Network and Out-of-Network services:

- **Except for Emergencies, all Hospitalizations and most outpatient procedures require Prior Authorization.** You must ask Your Provider to contact Us at least two (2) days prior to a scheduled Hospital admission, outpatient surgery, or other outpatient procedure (except for emergencies) to obtain Prior Authorization. If You are admitted to a Facility prior to the date Authorized by Us, then You will be responsible for all charges related to the unauthorized days.
- **We will Authorize only Medically Necessary Covered Services.** If You obtain services, which are not Medically Necessary or the services are not Authorized by Us, then You will be responsible for all charges for those services.
- You are responsible for obtaining a referral from Your PCP for all Covered Services rendered by a Specialist. This requirement does not apply to Emergency Services, obstetrical and gynecological care from an In-Network Provider and mental health and substance abuse services from an In-Network Provider. You or Your PCP must provide notice of the referral to the Health Plan prior to services being rendered by the Specialist. If a PCP referral is required and You do not obtain one, the services rendered by the Specialist will not be Covered under the Contract. Please be aware that obtaining a referral is not itself a guarantee of payment for services]
- **Intentional material misrepresentation:** If We Authorize a service that We later determine was based on an intentional material misrepresentation about Your health status, payment of the service will be denied. You will be responsible for all charges related to that service.
- **Notification letter:** When We approve or deny a Prior Authorization request, We will send a notification letter to You and Your Provider.
- **Right to Appeal:** You have the right to Appeal any Utilization Management Program denial regarding Medical Necessity. Please see the Appeal procedures in Section 7.
- **Attending Physician responsibility:** Under all circumstances, the attending Physician bears the ultimate responsibility for the medical decisions regarding Your treatment.
- **Prior Authorization requirements are subject to change from time to time.** Please ask Your Provider to call Customer Service at **855-449-2889** to determine whether a Covered Service requires Prior Authorization. The Prior Authorization phone number is located on the back of Your Member ID Card.

It is Your responsibility to ensure that Your Provider contacts us to obtain Prior Authorization. Please call Our Customer Service Department at 855-449-2889 to determine whether a Covered Service requires Prior Authorization.

1.4 Access to Services.

We make every effort to ensure that Your access to Covered Services is quick and easy and the services are reasonably available. If You wish to see a particular Provider that is not accepting new patients or is no longer Participating in Our Network, please call Our Customer Service Department at **855-449-2889**. We can help You find another Participating Provider that meets Your needs. You may also nominate Your Non-Participating Provider to become a Participating Provider with Coventry, or You may nominate Your Non-Participating Provider under the Consumer Choice Option. Please call Our Customer Service Department for more information.

Continuity of care is especially important to Us. If Your Participating Provider unexpectedly stops Participating with Us while You are in the middle of treatment, please call Us so We can help You continue treatment with another Participating Provider. If You are suffering from a terminal or chronic illness or are an inpatient, We will allow You to continue Your treatment with Your Non-Participating Provider. In this case, We will continue to pay for the Covered Services You receive from Your Non-Participating Provider for one hundred and twenty (120) days following the Provider's termination from Our Network.

1.5 Copayments, Coinsurance, and Deductibles

Your Copayment, Coinsurance, and Deductible amounts are listed in Your Schedule of Benefits. You are responsible for paying Copayments to Your Provider at the time of service. Coinsurance and Deductible amounts, based on the Health Plan's reimbursement to the Provider, may be due to the Provider before or at the time of service. The typical order of payment of these amounts on claims is as follows: Copayments are applied first, Deductible's are applied second, and Coinsurance's are applied last. However, please be aware that Your specific Plan may have different rules. Please see Your Schedule of Benefits for the specific rules of Your Plan.

In-Network. If You receive In-Network Covered Services, You are responsible only for the applicable Copayment, Deductible, and/or Coinsurance amounts noted in Your Schedule of Benefits.

Out-of-Network. If You receive Out-of-Network Covered Services, You are responsible for the applicable Copayment, Deductible, and/or Coinsurance amounts noted in Your Schedule of Benefits, plus any amount in excess of the Out-of-Network Rate ("ONR"). Please see Section 1.7 for more information on the Out-of Network Rate and Your potential Out-of-Network liability.

Individual Deductible. You must satisfy Your calendar year Individual Deductible before the Health Plan will pay for Your Covered Services, unless the calendar year Family Deductible is satisfied first. After You satisfy Your calendar year Individual Deductible or the calendar year Family Deductible is satisfied, the Health Plan will pay for Your Covered Services, minus any applicable Copayments or Coinsurance. Please refer to the Schedule of Benefitsfor details on your Individual Deductible.

Family Deductible. The Family Deductible applies when two or more Members are enrolled in Your Plan. The Family Deductible is met by any combination of Members meeting the total Family Deductible. After the calendar year Family Deductible is satisfied, the Health Plan will pay for Covered Services, minus any applicable Copayments or Coinsurance, for each Member; provided, however, that if a Member satisfies the calendar year Individual Deductible prior to the calendar year Family Deductible being satisfied, the Health Plan will pay for Covered Services, minus any applicable Copayments or Coinsurance, for that Member. Please refer to the Schedule of Benefits for details on your Family Deductible.

We have Contractual arrangements with Participating Providers and other health care Providers, Provider Networks, pharmacy benefit managers, and other vendors of health care services and supplies ("Providers"). In accordance with these arrangements, certain Providers have agreed to

Discounted Charges.

A “Discounted Charge” is the amount that a Provider has agreed to accept as payment in full for Covered Services. A “Discounted Charge” does not include pharmaceutical rebates or any other reductions, fees or credits a Provider may periodically give Us. We will retain those amounts that are not “Discounted Charges.” However, We have taken those into consideration in setting the fees charged to provide services under this Plan.

Claims under the Plan and any Deductible, Copayment, Coinsurance and the Out of Pocket maximum as described in this Contract will be determined based on the Discounted Charge.

1.6 Out-of-Pocket Maximum (OOP).

The individual Out-of-Pocket Maximum is the total amount each Member must pay out of his or her pocket annually for In-Network Covered Services, unless the family Out-of-Pocket Maximum is satisfied first. The family Out-of-Pocket Maximum is the total out-of-pocket amount family Members must pay together annually for In-Network Covered Services, regardless of whether each Member satisfies his or her individual Out-of-Pocket Maximum. . Generally speaking, out-of-pocket expenses that accumulate to the Out-of-Pocket Maximum include deductibles, coinsurance, or copayments. The Out-of-Pocket Maximum amounts are listed in Your Schedule of Benefits. Please note that there is no Out-of-Pocket Maximum for Out-of-Network Covered Services.

1.7 Payment to Providers.

1.7.1 In-Network Providers (Participating Providers).

For In-Network Covered Services, the Participating Provider will bill the Health Plan directly for the services. You do not have to file any claims for these services.

You are responsible for payment of:

A. The applicable In-Network Copayment, Deductible, and/or Coinsurance amounts;

B. Services that require Prior Authorization, which were not Prior Authorized;

C. Services that are not Medically Necessary; and

D. Services that are not Covered Services.

1.7.2 Out-of-Network Providers (Non-Participating Providers).

For Out-of-Network Covered Services, the Non-Participating Provider typically expects You to pay for the services. If so, You should submit a claim to Us for reimbursement **within twelve (12) months** and We will send the payment directly to You. However, if You assign payment of the services to the Non-Participating Provider, We will send the payment to the Non-Participating Provider.

Our payment for Out-of-Network Covered Services is limited to the **Out-of-Network Rate**, less the applicable Out-of-Network Copayment, Deductible, and/or Coinsurance amounts You are required to pay under Your Plan.

Out-of-Network Rate (ONR). The ONR is the Allowed Amount for charges billed by Non-Participating Providers. The ONR is based on a percentage of what Medicare would pay the same Provider for the same service.

If the amount You are billed by a Non-Participating Provider is equal to or less than the ONR amount, the charges should be completely Covered by Us, except for any Out-of-

Network Copayment, Deductible, and/or Coinsurance amounts You are required to pay under Your Plan. However, if the amount You are billed by the Out-of-Network Provider is greater than the ONR amount, You must pay the amount in excess of the ONR amount, in addition to Your Copayment, Deductible, and/or Coinsurance amounts.

Please Remember

In addition to the Out-of-Network Copayment, Deductible, and/or Coinsurance amounts that You are required to pay for Out-of-Network Covered Services,
You are also responsible for paying the billed charges that exceed the ONR amount We pay Non-Participating Providers.
This excess amount may be substantial.

Here is an example of what Your costs could be using an In-Network Participating Provider under the scenario detailed below.

IN-NETWORK RULES	IN-NETWORK AMOUNTS
(A) Total amount billed by the Participating Provider for a procedure:	$12,000
(B) Our Allowed Amount for the procedure, as indicated in the In-Network Provider's Contract with Us:	$10,000
Your In-Network Deductible:	$2,000
(C) We subtract Your Deductible from (B):	$10,000 - $2,000 = $8,000
Your In-Network Coinsurance:	30%
(D) We apply Your Coinsurance to (C):	30% of $8,000 = $2,400
Difference between (A) and (B): **PLEASE NOTE:** Because We have a Contract with the Participating Provider, You are not responsible for paying the difference between the total billed amount and the Allowed Amount.	$12,000 - $10,000 = $2,000 **(You Are Not Required to Pay This Amount)**
Total Amount We Pay for Procedure:	$10,000 (Our Allowed Amount) – $2,000 (Your Deductible) – $2,400 (Your Coinsurance) $5,600
Total Amount You Pay for Procedure:	$2,000 (Your Deductible) +$2,400 (Your Coinsurance) $4,400

By contrast, here is an example of what Your costs could be using an Out-of-Network Non-Participating Provider under a similar scenario detailed below.	
OUT-OF-NETWORK RULES	**OUT-OF-NETWORK AMOUNTS**
(A) Total amount billed by Non-Participating Provider for a procedure:	$12,000
(B) Our Out-of-Network Rate (ONR) for the procedure. This is the amount We pay all Non-Participating Providers for this procedure:	$10,000
Your Out-of-Network Deductible:	$4,000
(C) We subtract Your Deductible from (B):	$10,000 - $4,000 = $6,000
Your Out-of-Network Coinsurance:	40%
(D) We apply Your Coinsurance to (C):	40% of $6,000 = $2,400
Difference Between (A) and (B): **PLEASE NOTE:** Because We do not have a Contract with the Non-Participating Provider, You are required to pay the difference between the total billed amount and the ONR.	$12,000 - $10,000= $2,000 **(You Are Required to Pay This Amount in Excess of the ONR)**
Total Amount We Pay for Procedure:	$10,000 (Our Allowed Amount) – $4,000 (Your Deductible) – $2,400 (Your Coinsurance) $3,600
Total Amount You Pay for Procedure:	$4,000 (Your Deductible) + $2,400 (Your Coinsurance) + $2,000 (Amount in Excess of ONR) $8,400

1.8 Premium Payment and Grace Period. The monthly Premium is due on the first (1st) day of each month.

There is a one month day grace period for Premium payments. In other words, if the required Premium payment is not paid on or before the first (1st) day of the month (i.e., the due date), it may be paid during the grace period. This Contract will stay in force during the grace period. If the Premium payment is not received by the end of the grace period, Your Coverage under the Contract will be terminated effective at 11:59 p.m. on the last day of the grace period. If Your Coverage is terminated on the last day of the grace period, please be aware that You will be responsible for the Premium payment owed during the one month day grace period. You will be responsible for the cost of any health care services You receive after the grace period.

IF THE HEALTH INSURANCE MARKETPLACE HAS DETERMINED THAT YOU ARE A PERSON ELIGIBLE TO RECEIVE ADVANCE PAYMENT OF THE PREMIUM TAX CREDIT THE FOLLOWING APPLIES TO YOUR COVERAGE RATHER THAN THE ABOVE SECTION 1.8.

Premium Payment and Grace Period for Persons Receiving Advance Payment of the Premium Tax Credit. The monthly Premium is due on the first (1st) day of each month. There is a three (3) month grace period for Premium payments. In other words, if the required Premium payment is not paid on or before the first (1st) day of the month (i.e., the due date), it may

be paid during the grace period. During the first month of the grace period, We will continue to pay claims for Covered Services During the second and third months of the grace period, We will suspend payment of any claims until We receive the past due Premiums. If the payment is not received for all outstanding Premium by the end of the grace period, Your Coverage under the Contract will be terminated effective at 11:59 p.m. on the last day of the first month of the grace period. You will be responsible for the cost of any health care services You receive after the last day of the first month of the grace period.

1.9 Changes in Premium or Benefits.

Your rates that begin on Your Member Effective Date will not change until January first of each year. Upon renewal and in accordance with applicable law, We may increase or decrease the Premium and/or Covered Services for all Members Covered under an Individual Contract in the event that any state or federal laws or regulations require Us to Cover additional services, reduce Coinsurance or Deductibles, or otherwise expand Coverage in order to meet new minimum standards.

In the event of such change, You will receive a notice via U.S. mail at Your last known address sixty (60) days prior to the change.

Renewals occur the following year and are effective on the first (1st) day of January. Age band changes occur each year and are included in the annual renewal.

1.10 How to Contact the Health Plan.

Whenever You have a question or concern, please call Our Customer Service Department at the telephone number listed on Your Member ID card, or visit Our website at www.chctn.com. Our contact information is listed as follows.

For Customer Service Department and To Submit Claims	
Hours	Monday-Friday: [8:00 am to 6:00 pm EST]
Toll Free Telephone Number	**855-449-2889**
Address	[Coventry Health and Life Insurance Company P.O. Box 7813 London, KY 40742]
To Request a Review of Denied Claims or to Appeal a Denial of Authorization of Services	
Hours	Monday-Friday: [8:00 am to 6:00 pm EST]
Toll Free Telephone Number	**855-449-2889**
Address	**[**Coventry Health and Life Insurance Company 5350 Poplar Ave, Suite 390 Memphis, Tennessee 38119] Attn: Appeals Department
To Register a Complaint	
Hours	Monday-Friday: [8:00 am to 6:00 pm EST]
Toll Free Telephone Number	**855-449-2889**
Address	[Coventry Health and Life Insurance Company 5350 Poplar Ave, Suite 390 Memphis, Tennessee 38119] Attn: Quality Improvement Department

1.11 Verification of Benefits.

When We provide information about which health care services are Covered under Your Plan that information is referred to as verification of benefits. When You or Your Provider call Our Customer Service Department at **855-449-2889** during regular business hours to request verification of benefits, a Health Plan representative will be immediately available to provide assistance. If the health care services are verified as a Covered benefit, the Customer Service representative will advise whether Prior Authorization is required.

Please be aware that verification of benefits is not a guarantee of payment for services.

SECTION 2
ENROLLMENT, ELIGIBILITY, AND EFFECTIVE DATES

2.1 Eligibility.

2.1.1 Subscriber Eligibility.

To be eligible to be enrolled as a Subscriber, You must apply to the Health Insurance Marketplace. The Health Insurance Marketplace will notify Us if You are a Qualified Individual.

2.1.2 Dependent Eligibility.

To be eligible to be enrolled as a Dependent, an individual must:

A. Be the lawful spouse of the Subscriber or be a child of the Subscriber who is:

A child under age twenty-six (26):

Who is the birth child of the Subscriber or the Subscriber's spouse; or

Who is legally adopted by or placed for adoption with the Subscriber or the Subscriber's spouse; or

For whom the Subscriber or the Subscriber's spouse is the court-appointed legal guardian.

A child age twenty-six (26) or older if the following criteria is met:

The child is the birth or adopted child of the Subscriber or the Subscriber's spouse; or

The Subscriber or the Subscriber's spouse is the court-appointed legal guardian; **and**

The child is mentally or physically incapable of earning a living, and the child is chiefly dependent upon the Subscriber for support and maintenance, provided that the onset of such incapacity occurred before the child was twenty-six (26).

Note: Proof of incapacity and dependency must be furnished to Us upon enrollment of Your Dependent child, or within thirty-one (31) days of the Dependent's twenty-sixth (26^{th}) birthday and subsequently thereafter, but not more frequently than annually after the two (2) year period following the Dependent's attaining age twenty-six (26).

2.2 Persons Not Eligible to Enroll.

Any person that the Health Insurance Marketplace determines is not a Qualified Individual.

2.3 Enrollment and Effective Dates.

A. **Effective Date.** Your enrollment will be effective as of the date provided to Us by the Health Insurance Marketplace.

B. **Newborns**. A newborn child shall be Covered for the first thirty-one (31) days from the date of birth. For Coverage to continue beyond the first thirty-one (31) days, You must apply to the Health Insurance Marketplace to enroll the child under a Plan.

C. **Adopted Children.** A newly adopted child shall be Covered for the first thirty-one (31) days from the date of placement for adoption or the final decree of adoption, whichever occurs first. For Coverage to continue beyond the first thirty-one (31) days, You must apply to the Health Insurance Marketplace to enroll the child under a Plan.

2.4 Notification of Change in Status.

You must notify the Health Insurance Marketplace, in writing, of any changes in Your status or the status of any Dependent within sixty (60) days after the date of the status change. Events that qualify as a change in status include, but are not limited to, changes in address, divorce, marriage, death, dependency status, incarceration, loss of legal residency in the United States, Medicare eligibility, or Coverage by another insurance policy. Coventry requires notice of Medicare eligibility or Coverage by another payer for purposes of coordinating benefits. We should be notified within a reasonable time of the death of any Member. For more information, call Customer Service at **855-449-2889.**

2.5 If You Become Eligible for Medicare While Covered Under Coventry.

Under the terms of this Contract, Medicare will pay primary, to the extent stated in federal law. In the event that You are eligible for Medicare Parts A, B, and/or D, We will base Our payment upon the benefits Covered by the applicable Medicare Part, regardless of whether or not You are actually enrolled. As long as You continue to pay Premium to Us, You will remain enrolled in Your Coventry policy, subject to the reduced benefits described above. Please direct any questions regarding Medicare eligibility and enrollment to Your local Social Security Administration office.

SECTION 3
TERMINATION OF COVERAGE

3.1 Termination.

A. Termination by Subscriber.

The Subscriber may terminate Coverage for himself/herself and any enrolled Dependents under the Contract for any reason by providing fourteen (14) days advance written notice to the Health Insurance Marketplace. . For notices received on the 1st through 15th day of the month, termination will take effect on the first day of the month in which the notice was received. For notices received on the 16th through 31st day of the month, termination will take effect on the first day of the month following the month in which the notice was received, unless the Health Plan agrees to an earlier termination. The notice of termination should be sent to:

[insert Health Insurance Marketplace]

B. Termination by Us.

1. Non-Payment of Premium.

a. Non-Payment of Premiums.

In the event that We do not receive payment of all outstanding Premium by the end of the one month grace period, Your Coverage under the Contract will be terminated at 11:59 p.m. on the last day of the grace period. If Your Coverage is terminated for non-payment of the Premium, You will be responsible for the cost of any health care services You receive after the grace period.

IF THE HEALTH INSURANCE MARKETPLACE HAS DETERMINED THAT YOU ARE A PERSON ELIGIBLE TO RECEIVE ADVANCE PAYMENT OF THE PREMIUM TAX CREDIT THE FOLLOWING APPLIES TO TERMINATION OF YOUR COVERAGE RATHER THAN THE ABOVE SECTION B.

In the event that We do not receive payment of all outstanding Premium by the end of the three (3) month grace period, Your Coverage under the Contract will be terminated at 11:59 p.m. on the last day of the first month of the grace period. If Your Coverage is terminated for non-payment of the Premium, You will be responsible for the cost of any health care services You receive after the last day of the first month of the grace period.

2. Reinstatement After Termination for Non-Payment of Premium.

Reinstatement of Your Coverage will be as permitted by and in accordance with the Health Insurance Marketplace.

3. Fraud.

If You or Your enrolled Dependents participate in fraudulent or criminal behavior in connection with enrollment or Coverage under the Contract, Coverage for You and Your enrolled Dependents shall end at 11:59 p.m. upon the date set forth in Our notice of termination to the Subscriber. Examples of fraud include, but are not limited to the following:

a. Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts, including using Your Member ID card to obtain goods or services that are not prescribed or ordered for You or to which You are otherwise not legally entitled. In this instance, Coverage for the Subscriber and all Dependents will be terminated.

b. Knowingly allowing any other person to use Your Member ID card to obtain services. If a Dependent allows any other person to use his/her Member ID card to obtain services, the Coverage of the Dependent that allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his/her Member ID card to obtain services, the Coverage of the Subscriber and his/her Dependents will be terminated.

c. Intentionally misrepresenting or giving false information in Your application for Coverage to the Health Insurance Marketplace that is material to Our acceptance of Your enrollment.

d. Engaging in fraudulent activity with respect to obtaining health services, including but not limited to, using and obtaining medications in a manner that contradicts Your Prescription or standard prescribing practices.

4. Dependent Eligibility Ends Due to Attainment of Limiting Age, Unless Disabled.

When the Dependent attains the age of twenty-six (26), unless disabled, the Dependent shall no longer meet the eligibility requirements for Dependents, as set forth in this Contract. The Dependent is entitled to apply to the Health Insurance Marketplace for Coverage if the Dependent is a Qualified Individuall.

The Dependent shall be considered Totally Disabled if the Dependent is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

5. Dependent Eligibility Ends Due to Subscriber Termination.

If a Subscriber requests to terminate the Contract and the termination results in only children under the age of nineteen (19) remaining on the Contract, the Dependent(s) Coverage under the Contract will also terminate on the same termination date as the Subscriber. The Dependent(s) are entitled to apply to the Health Insurance Marketplace for Coverage if the Dependent is a Qualified Individual.

6. Termination of Dependent Spouse Coverage Due to Death or Divorce of Subscriber Spouse.

If the Dependent spouse dies or enters a valid divorce decree, Coverage as a Dependent spouse will be terminated. The spouse is entitled to apply to the Health Insurance Marketplace for Coverage if the spouse is a Qualified Individual.

7. Termination of Coverage in the Market.

a. Termination of Plan Type.

If We cease to offer the Coventry individual policy in the individual market, We will provide to all Members Covered by such policy at least sixty (60) days notice prior to the discontinuance of the policy. In such an instance, We will:

- Offer such Members the option to purchase all other individual policies currently being offered to or renewed by individuals for which the Member is eligible; and

- Act uniformly without regard to the claims experience or any health status related factor of Members or individuals eligible to be Members.

b. Ceasing To Do Business in Individual Market.

If We discontinue offering all Plans in the individual market, We will provide to all Members and the state Commissioner of Insurance at least one hundred eighty (180) days notice prior to the discontinuance of all policies in the individual market. In such an instance, We will:

- Not issue Coverage in the individual market for five (5) years beginning with the date of the last policy or Contract in that market not renewed.

- Act uniformly without regard to the claims experience or any health status related factor of Members or individuals eligible to be Members.

Upon such termination, You may be eligible for a special enrollment period. Contact the Health Insurance Marketplace.

8. Eligibility Requirements.

Your Coverage shall continue as long as You continue to meet the eligibility requirements as required by the state and federal laws governing the Health Insurance Marketplace and shall cease if You no longer meet eligibility requirements.

9. Moving out of the Service Area.

At least sixty (60) days notice of termination of Your Coverage will be provided by U.S. mail if You no longer live in the Service Area. Upon such termination, You may be eligible to apply to the Health Insurance Marketplace for other available Health Insurance Marketplace Plans.

10. Incarceration.

Upon such termination, You may be eligible for a special enrollment period. Contact the Health Insurance Marketplace. For purposes of termination of eligibility, “incarceration” means incarceration other than incarceration pending the disposition of charges.

3.2 Renewal.

Renewals occur on the first (1st) day of January, each year. Your Plan is renewable as long as Premiums are paid, and You and Your Dependents continue to meet eligibility requirements and remain in the Coventry Health and Life Insurance Company Service Area. We will not change Your Premium because of claims filed or due to a change in Your health since becoming a Member. Renewal Premiums are based on Your original Premium, age, gender, area of residence, and the type of Plan You have.

3.3 Effect of Termination.

If Your Coverage under the Contract terminates, all rights to receive Covered Services shall cease as of 11:59 p.m. on the date of termination.

Member ID cards are Our property and, upon request, shall be returned to Us within thirty-one (31) days of the termination of Your Coverage. Member ID cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.

Your Coverage shall not be terminated on the basis of Your health status or the exercise of Your rights under Our complaint procedures.

Termination will be without prejudice to any claim originating prior to the effective date of termination.

3.4 Certificate of Creditable Coverage.

At the time Coverage terminates, You are entitled to receive a certificate verifying the type of Coverage, the date of any waiting periods, and the date any creditable Coverage began and ended.

A certificate of creditable Coverage under this Contract will be issued:

A. When a Subscriber or Dependent ceases to be Covered under this Contract for any reason, or

B. When requested by a Subscriber or Dependent within twenty-four (24) months of the termination of Coverage.

SECTION 4
CLAIMS FOR REIMBURSEMENT OF SERVICES RENDERED BY NON-PARTICIPATING PROVIDERS

4.1 Notice of Claim and Timely Submission of Claim.

Participating Providers are responsible for submitting claims directly to Us for Covered Services provided to Members. However, when You receive Covered Services from a Non-Participating Provider, You must provide Us written notice of the claim within twelve (12) months of the date of service. Except in the absence of the Member's legal capacity, claims or bills will not be accepted from Members later than one (1) year after the date of service. Such services must have been provided in accordance with Our Utilization Management Program and Prior Authorization policies and procedures. Failure to furnish such documentation within the specified period shall invalidate any such claim.

Upon notice of a claim, CHL shall furnish claim forms to the claimant for filing for the proof of loss. If We do not supply claim forms to You within ten (10) working days after receipt of Your notice, You will be considered to have complied with these requirements. Claims for Covered Services rendered by Non-Participating Providers should be sent to Our Claims Department at the following address.

Carelink from Coventry Claims Department
[P.O. Box 7813
London, KY 40742]

Notice given by You or on Your behalf to Us at the address above or to any Authorized agent of Ours with sufficient information to identify You shall be deemed notice to Us.

4.2 Timely Payment of Claims.

Upon timely receipt of a claim for a Covered Service, We will promptly make payment to the person or institution providing the Covered Service, or at Our discretion, We may make payment directly to the Subscriber. We will pay a Non-Participating Provider the Out of Network, however, the Non-Participating Provider may balance bill You for charges over the amount We have Contracted with the Participating Provider.

4.3 Legal Action.

No action at law or equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished to CHL as required above. No action shall be brought after the expiration of two (2) years after the time written proof is required to be furnished.

SECTION 5
COVERED SERVICES

5.1 Schedule of Covered Services.

Under this PP0 Plan, inpatient, outpatient, and other Covered Services are available through both In-Network (Participating) Providers and Out-of-Network (Non-Participating) Providers. Benefits under this Plan are subject to Our Utilization Management Program. Please be aware that Coverage may be denied if the Covered Services You receive are not compliant with the Utilization Management Program. See Section 1.3 for more information on Our Utilization Management Program.

Keep in mind that using a Participating Provider (Your In-Network benefits) will usually cost You less than using a Non-Participating Provider (Your Out-of-Network benefits). This is because Participating Providers are Contracted with Us to provide health care services to Members for a lower fee, whereas Non-Participating Providers are not Contracted with Us. Please see Section 1 for more information on how Your In-Network and Out-of-Network benefits work.

Please note that the Health Plan Covers only those health care services and supplies that are:

(1) deemed Medically Necessary,

(2) Authorized, if Authorization is required,

(3) listed in as Covered Service in the Contract and not Excluded under the Contract, and

(4) incurred while the Member is eligible for Coverage under the Contract

See Section 1.3. Prior Authorization is required for some services. It is advised that either You or Your Provider call Customer Service for clarification if there are any concerns. Benefits may be subject to other limitations, as outlined in this document or affiliated schedules and riders.

COVERED SERVICES

Health Plan Covers only those Covered Services and supplies that are (1) deemed Medically Necessary, (2) Authorized, if Authorization is required, (3) listed below and not excluded in the Exclusions and Limitations set forth in this Schedule, and (4) incurred while the Member is eligible for Coverage under the Contract.

Those health care services and supplies that are Covered Services under the Contract are listed below. This list is subject to the Exclusions and limitations set forth in this Schedule. In the event of any conflict between the list of Exclusions and limitations set forth in this Schedule and the Covered Services list below, the list of Exclusions and limitations shall govern.

SCHEDULE OF COVERED SERVICES THIS DETAILS THE COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHL TO BE MEDICALLY NECESSARY AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6	
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
Allergy	Covered Service. Testing, diagnosis, treatment, allergy serum, and the administration of injections.
Ambulance	Covered Service. Ambulance transport is a Covered Service when deemed Medically Necessary.
Bone Density Testing	**See "Preventive Services" in this Section.**
Breast Reconstruction	Covered Service when consistent with the federal Women's Health and Cancer Rights Act of 1998. If You have a mastectomy and elect Reconstructive Surgery in connection with the mastectomy, Coverage will be provided for: 1. Reconstruction of the breast on which the mastectomy was performed; 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3. Prostheses and physical complications of mastectomy, including lymphedema. Coverage will be provided in a manner determined in consultation between You and Your attending Physician. Reconstructive breast surgery following a mastectomy will be covered regardless of the lapse of time since the mastectomy. **Post-Mastectomy Care** Following a Medically Necessary mastectomy, the decision whether to discharge the Member is made by the attending Physician in accordance with currently accepted medical criteria.
Cardiac Rehabilitation Therapy **(Outpatient)**	Covered Service.
Chemotherapy for Cancer	Covered Service.
Child Wellness Care	**See "Preventive Services" in this Section.**

SCHEDULE OF COVERED SERVICES THIS DETAILS THE COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHL TO BE MEDICALLY NECESSARY AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6	
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
Cleft Palate	Medically Necessary and appropriate therapeutic and rehabilitative services performed in a Physician's office, outpatient Facility or Home Health setting and intended to restore or improve bodily function lost as the result of cleft palate. Outpatient, Home Health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from cleft palate. The services must be performed by, or under the direct supervision of a licensed therapist, upon written Authorization of the treating Physician. Speech therapy is Covered only for disorders of articulation and swallowing, resulting from cleft palate."
Clinical Trials	Covered Service. Coverage is provided for routine Patient Costs associated with a cancer clinical trial for which a Member voluntarily participates. Coverage of routine Patient Costs associated with a randomized and controlled Phase III and Phase IV clinical trial for the treatment of cancer will be covered if **all** of the following conditions are satisfied: 1. A written protocol is provided and includes selection criteria, objectives for the trial, expected outcomes, specific directions for administering the therapy and monitoring patients, a definition of quantitative measures for determining treatment response, and methods for documenting and treating adverse reactions; 2. The trial must be designed with therapeutic intent and not exclusively test toxicity or disease pathophysiology; 3. The trial must be in compliance with Federal Regulations relating to the protection of human subjects (e.g., National Institutes of Health (NIH), Food and Drug Administration (FDA)); 4. The trial must have Institutional Review Board (IRB) approval; 5. The treatment is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following: a. One of the National Institutes of Health. b. A National Institutes of Health cooperative group or center. c. The United States Food and Drug Administration in the form of an Investigational new drug application. d. The United States Department of Defense. e. The United States Department of Veterans' Affairs. f. A qualified research entity that meets the criteria established by the National Institutes of Health for grant eligibility. g. A panel of qualified recognized experts in clinical research within academic health institutions in this state; 6. The trial must be conducted according to appropriate standards of scientific integrity; 7. The trial cannot duplicate existing studies;

SCHEDULE OF COVERED SERVICES THIS DETAILS THE COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHL TO BE MEDICALLY NECESSARY AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6	
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
	8. The personnel providing the treatment or conducting the study: a. Are providing the treatment or conducting the study within their scope of practice, experience and training, and are capable of providing the treatment because of their experience, training, and volume of patients treated to maintain expertise. b. Agree to accept reimbursement as payment in full from the accountable Health Plan at the rates that are established by the Plan and that are not more than the level of reimbursement applicable to other similar services provided by health care Providers with the Plan's Provider Network; 9. There is no clearly superior, non-Investigational treatment alternative; and 10. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as any non-Investigational alternative.
Colorectal Cancer Screenings	**See "Preventive Services" in this Section.**
Dental-Related Anesthesia and Hospital or Ambulatory Facility Charges	Covered Service. Dental-related anesthesia and Hospital or Facility charges for dental services performed in a Hospital or ambulatory surgical Facility in connection with dental procedures for: 1. Children seven (7) years of age or younger; 2. Persons with serious mental or physical conditions; 3. Persons with significant behavioral problems; where the Provider treating the patient certifies that because of the patient's age, condition, or problem, Hospitalization or general anesthesia is required in order to safely and effectively perform the dental procedure(s).
Diabetic Treatment, Supplies and Equipment	Covered Service. Coverage is provided for Medically Necessary equipment, supplies, one dilated eye exam/year, pharmacologic agents, and outpatient self-management training and education, including medical nutrition therapy. Medically Necessary equipment, supplies, and pharmacological agents include: Glucometers, test strips and related accessories for glucose monitors, insulin, injection aids and supplies, injection devices, insulin cartridges, insulin pumps, insulin infusion devices, oral agents for diabetes maintenance, and other equipment, supplies and drugs determined to be Medically Necessary and consistent with the standards of the American Diabetes Association. Routine foot care such as removal or reduction of corns and calluses and clipping of the nails is covered for diabetics only. The following are Covered under Your Prescription Drug benefits: 1. Oral medications; 2. Test strips; 3. Lancets;

SCHEDULE OF COVERED SERVICES THIS DETAILS THE COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHL TO BE MEDICALLY NECESSARY AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6	
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
	4. Syringes; and 5. Insulin.
Dialysis	Covered Service. Hemodialysis and peritoneal services provided by outpatient or inpatient facilities or vendors. Home hemodialysis, equipment, supplies, and maintenance are covered for homebound Members as certified by their attending Physician.
Durable Medical Equipment (DME)	Medically Necessary and appropriate medical equipment or items that: 1. in the absence of illness or injury, are of no medical or other value to You; 2. can withstand repeated use in an ambulatory or home setting; 3. require the prescription of a Physician for purchase; 4. are approved by the FDA for the illness or injury for which it is prescribed; and 5. are not solely for Your convenience. Covered Services a. Rental of Durable Medical Equipment - Maximum allowable rental charge not to exceed the total Maximum Allowable Charge for purchase. If You rent the same type of equipment from multiple DME Providers, and the total rental charges from the multiple Providers exceed the purchase price of a single piece of equipment, You will be responsible for amounts in excess of the Maximum Allowable Charge for purchase. b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment. c. Supplies and accessories necessary for the effective functioning of Covered Durable Medical Equipment. d. The replacement of items needed as the result of normal wear and tear, defects or obsolescence and aging. Insulin pump replacement is Covered only for pumps older than 48 months and only if the pump cannot be repaired.
Emergency Services	Covered Service for those health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, which would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his/her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in: 1. Placing the Member's health in serious jeopardy; 2. Placing the health of a pregnant Member and the health of her unborn child in serious jeopardy; 3. Serious impairment to bodily function; or 4. Serious dysfunction of any bodily organ or part. Payment of services shall be based on retrospective review of Your presenting history, symptoms, and Hospital records.

SCHEDULE OF COVERED SERVICES THIS DETAILS THE COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHL TO BE MEDICALLY NECESSARY AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6	
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
Eyeglasses and Corrective Lenses	Covered Service for the first pair of eyeglasses with lenses or corrective lenses following cataract surgery. Standard contact lenses will be Covered and premium lenses will be Excluded.
Family Planning and Reproductive Services	Medically Necessary and appropriate family planning services and those services to diagnose and treat diseases that may adversely affect fertility. 1. Covered Services a. Benefits for: (1) family planning; (2) history; (3) physical examination; (4) diagnostic testing; and (5) genetic testing. b. Sterilization procedures. c. Services or supplies for the evaluation of infertility. d. Medically Necessary and appropriate termination of a pregnancy. e. Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting, insertion and removal.
Genetic Counseling and Testing	Covered Service. 1. Genetic counseling and studies that are needed for diagnosis and treatment of genetic defects when the result of the genetic test will directly impact treatment for the Member; or 2. There is a history of an inheritable genetic disease and the published Peer-Reviewed Medical Literature documents that its use will improve outcomes; or 3. There is a substantial familial risk for being a carrier for a particular detectable mutation that is recognized to be attributable to a specific genetic disorder.
Habilitative and Rehabilitation Services	Covered Service. Habilitative Services are health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Hearing Aid	Hearing aids are Covered for members under the age of 18, up to **one hearing aid per ear every 3 years**

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
Home Health Care	Covered Service. Covered when all of the following requirements are met: 1. The service is ordered by a Physician; 2. Services required are of a type that can only be performed by a Physician, licensed nurse, physical therapist, speech therapist, or occupational therapist; 3. The services are an alternative to Hospitalization; 4. Part-time, intermittent services are required; 5. A treatment Plan has been established and periodically reviewed by the ordering Physician; 6. The services are Authorized by the Health Plan; 7. The agency rendering services is Medicare certified and licensed by the State of location; and 8. The Member is home bound as certified by his/her attending Physician.
Hospice Services	Covered Service if **all** of the following conditions are met: 1. Your Provider certifies that You have a life expectancy of six (6) months or less; 2. Before the services are provided, Your Provider prepares a written treatment plan Authorizing the services; and 3. A state licensed Hospice within the Service Area is providing Medically Necessary Hospice Services.
Inherited Metabolic Disorder-PKU	Treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Physician
Inpatient Hospital Care	Covered Service. Coverage is dependent on the establishment of Medical Necessity for the care. Semi-private accommodations are covered. Private, if determined to be Medically Necessary, are Covered. Maternity and delivery services (including routine nursery care and Complications of Pregnancy). If the Hospital or Physician provides services to the baby and submits a claim in the baby's name, benefits may be Covered for the baby and mother as separate Members, requiring payment of applicable Member Copayments and/or Deductibles.
Laboratory Services	Covered Service.
Mammogram	**See "Preventive Services" in this Section.**
Maternity	1. Surgical and Medical Services. a. Initial office visit and visits during the term of the pregnancy. b. Diagnostic Services.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
	c. Delivery, including necessary pre-natal and post-natal care. d. Medically Necessary abortions required to save the life of the mother. 2. Hospital services required in connection with pregnancy and Medically Necessary abortions as described above. The Hospital (nursery) charge for well-baby care is included in the mother's Benefits for the Covered portion of her Admission for Pregnancy Care.
Medical Supplies, Disposable	Those Medically Necessary and appropriate expendable and disposable supplies for the treatment of disease or injury. 1. Covered Services a. Supplies for the treatment of disease or injury used in a Physician's office, outpatient Facility or inpatient Facility b. Supplies for treatment of disease or injury that are prescribed by a Practitioner and cannot be obtained without a Physician's prescription. 2. Exclusions a. Supplies that can be obtained without a prescription (except for diabetic supplies). Examples include but are not limited to: (1) adhesive bandages; (2) dressing material for home use; (3) antiseptics, (4) medicated creams and ointments; (5) cotton swabs; and (6) eyewash.
Mental Health and Substance Abuse	Coverage is provided for Medically Necessary treatment of Mental Health Conditions and Chemical Dependency Services through partial or full day outpatient programs or nonresidential inpatient treatment. As an alternative to Hospital inpatient days, if less costly residential treatment, partial Hospitalization, or crisis respite care for the patient is appropriate, the Plan shall provide for this care at the rate of two (2) alternate care days to one (1) day of inpatient Hospital treatment. See Your Schedule of Benefits for information. CHL Contracts with a Mental Health and Substance Abuse Designee to coordinate, determine Medical Necessity, and Prior Authorize the diagnosis and treatment of all Mental Health Conditions.
Newborn Care	The Covered Services for eligible newborn children shall consist of Coverage for Injury or Illness, including Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of the newborn to and from the nearest Facility that is appropriately staffed and equipped to treat the newborn's condition. Coverage is provided for all newborns to be tested or screened for phenylketonuria (PKU), hypothyroidism, galactosemia, and such other common metabolic or genetic diseases that would result in mental retardation or physical dysfunction. Coverage is also provided for newborn hearing screening examinations, any necessary rescreening, audiological assessment and any requisite follow-up.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
Non-Emergency Care When Travelling Outside the U.S.	When You need to locate a Hospital or Physician, You can call the Customer Service Center to help you locate a Physician. You will only be responsible for the Plan's usual Out-Of-Pocket expense for Out-Of-Network benefits (i.e., non-Covered expenses, Deductible, Copayment and/or Coinsurance). Your out-of-pocket expenses may be significantly higher than if You had seen an In-Network Provider. In an Emergency, You should go to the nearest Hospital and call the Customer Service Center if You are admitted. You may have to pay the Hospital directly and then file a claim for reimbursement.
Occupational Therapy	**Refer to Short-Term Therapies.**
Oral Surgery Services	Covered Service. Removal of tumors and cysts of the jaws, lips, cheeks, tongue, roof and floor of the mouth, and removal of bony growths of the jaw, soft, and hard palate. Covered Service, if as a result of trauma, You must seek treatment within twenty-four (24) hours of the accidental injury, unless incapacitated at time of trauma. Coverage is limited to the functional restoration of structures and treatment resulting in fracture of jaw or laceration of mouth, tongue, or gums.
Oral Surgery Services for Treatment of Temporomandibular Joint (TMJ)	Covered Service. Surgical and non-surgical medical treatment of TMJ dysfunction is covered if a Physician administers the treatment. Treatment for TMJ may include surgery for the correction of the bone or joint structure of the maxilla or mandible, such that the normal character and essential function of such bone structure is restored. Non-surgical treatment may include history and examination; diagnostic radiographs; splint therapy; and diagnostic or therapeutic masticatory muscle and temporomandibular joint injections.
Orthotics	Covered Service, unless specifically excluded. Orthotics are accessories that provide stability, external control, correction, and support for a body part.
Outpatient Services	Covered Service. Diagnostic or therapeutic services that are: 1. Covered Services; and 2. Performed outside the Physician's office.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
Outpatient / Ambulatory Surgery	Covered Service. Covered surgery not performed in a Physician's office or inpatient setting.
Ovarian Cancer Screenings	**See "Preventive Services" in this Section.**
Pap Smear	**See "Preventive Services" in this Section.**
Pediatric Vision	[Covered Service. Coverage includes yearly exam, frames, and lenses. See Your Schedule of Benefits for Coverage details. Standard contact lenses will be Covered and premium lenses will be Excluded. Covered Service for Members that are under age 19. For a description of the pediatric vision Covered Services and limitations, see Your Schedule of Benefits.
Physical Therapy	**Refer to Short-Term Therapies**
Prescription Drugs	Covered Service. Subject to the applicable limitations, Exclusions, Copayments, Coinsurance, and Deductibles, outpatient Prescription Drugs will be Covered when: • ordered by a Prescribing Provider for use by the Member, if the Prescribing Provider is lawfully able to prescribe Prescription Drugs, and • not limited or excluded elsewhere in this Contract; and • filled at a Participating Pharmacy [or Specialty Pharmacy], including a Mail Order Pharmacy, designated by Us (except for Emergency Services out of the Service Area); and • Prior Authorized, if applicable. Certain **Prescription Drugs** which are prescribed for the treatment of long-term or chronic conditions are considered to be Maintenance Drugs under the terms of this Contract. If You are prescribed a Maintenance Drug, You may obtain the first prescription fill for a 31-day supply and one additional Refill at a Participating Pharmacy that is a retail pharmacy. Before receiving the third fill of the Maintenance Drug at the Participating Pharmacy that is a retail pharmacy, You must notify Us of whether you want to use Your Mail Order Pharmacy benefit or continue to obtain Your Maintenance Drug at Participating Pharmacy that is a retail pharmacy. If You fail to inform Us of Your choice, then the third prescription fill (and any subsequent Refill of the Maintenance Drug) at a retail pharmacy will not be Covered. You may contact Us at any time to let Us know that You intent to use a Participating Pharmacy that is a retail pharmacy for future fills of Your Maintenance Drugs. In no event shall a Member receive coverage under this Contract for **Prescription Drugs** filled at a Participating Pharmacy unless he/she presents his/her ID card to the Participating Pharmacy. Prescriptions filled at a Participating Pharmacy must be submitted through the on-line claims adjudication process in order to be Covered. Members presently taking a prescription drug shall be notified at least thirty days prior to any deletions to the Formulary. Notifications will not be provided for generic substitutions.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
	The Member shall pay the Participating Pharmacy: • An amount up to the Prescription Drug Deductible, as applicable, and as identified in the Schedule of Benefits; • One hundred percent (100%) of the cost of a Prescription Drug dispensed when the Member fails to show his/her identification card at the Participating Pharmacy; • One hundred percent (100%) of the cost of a Prescription Drug or Specialty Drug dispensed at quantities above the approved amount; • One hundred percent (100%) of the cost of a Prescription Drug or Specialty Drug that is Excluded from Coverage under Your Prescription Drug benefit; • Any applicable Copayments and/or Coinsurance. Your annual Deductible for **Prescription Drugs** is as set forth in the Schedule of Benefits. The annual Deductible must be satisfied each calendar year before a Member may receive Coverage for **Prescription Drugs.** Total Member payments for a Covered Drug shall not exceed the retail price of the Prescription Drug. Payment for Covered Drugs is limited to the Contracted amount the Health Plan would normally pay, less the Member's applicable Copayment, Coinsurance and/or Deductible. The Copayment or Coinsurance for each Prescription Order or Refill of one Prescribing Unit of a Formulary generic or Formulary brand name other than a Specialty Drug is as set forth in the Schedule of Benefits. **Specialty Drugs** **Specialty Drugs** are Covered under this Contract in the amounts described below when they are: • Ordered by a prescribing Provider for use by a Member if the prescribing provider is lawfully able to prescribe such drugs, and • Not limited or excluded elsewhere in this Contract; and • Obtained from a Plan Approved Specialty Pharmacy; and • Prior Authorized; [and • Subject to quantity limits • Limited to no more than a 30 day supply per fill • Listed on Our Formulary. **Specialty Drugs** should be filled or Refilled through one of the Participating Specialty

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
	Pharmacies designated by the Health Plan in order to receive the highest level of Coverage. If You fill or Refill Your order for **Specialty Drugs** through a Non-Participating Specialty Pharmacy or Participating or Non-Participating Pharmacy, we will not provider any Coverage for the Prescription Drug. You shall pay the following to a Specialty Pharmacy, as applicable: • Prescription Drug Deductibles; and • Any applicable Coinsurance],Copayment. The applicable Coinsurance, Copayment You must pay for each Prescribing Unit of a **Specialty Drugs** is as set forth in the Schedule of Benefits. **Prescribing Units.** A **Prescribing Unit** is the amount of the Prescription Drug or Specialty Drug that will be dispensed for a single Copayment [or for which any minimum or maximum Coinsurance amount will be calculated]. For any drug, if two (2) or more different strengths, method of drug delivery, formulation or drug name are prescribed for use during the same time period, each will constitute a separate Prescribing Unit and Copayment/Coinsurance. We also reserve the right to cover the least number of tablets and/or capsules in order to obtain the daily dose needed as long as it is within the Plan's quantity limits and/or Plan's approved dose, each will constitute a separate **Prescribing Unit** and Copayment/Coinsurance. The **Prescribing Unit** of a Prescription Drug and/or Specialty Drugs dispensed by a Participating Pharmacy pursuant to one (1) Prescription Order or Refill shall be limited to the lesser of: • The quantity prescribed in the Prescription Order or Refill; or • A 31day supply as defined by Us; or • The quantity limit set by Us for a specific drug; or • The amount necessary to provide a [30-31] day supply according to the maximum dosage approved by the Food and Drug Administration for the indication for which the drug was prescribed; or • Depending on the form and packaging of the product, the following: (i) Tablets/capsules/suppositories – 100; or (ii) Oral liquids – 480 cc; or (iii) Commercially prepackaged items (such as but not limited to, inhalers, topicals, and vials) – 1 unit (i.e., box, tube or inhaler); [or (iv) Specialty Drugs– a sufficient amount to provide the prescribed amount for four (4) weeks.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
	Any Covered Drug that has a duration of action extending beyond one (1) month shall require the number of Copayments per **Prescribing Unit** that is equal to the anticipated duration of the medication. For example, Depo-Provera is effective for three (3) months and would require three (3) Copayments. The **Prescribing Unit** for insulin and diabetic supplies (insulin syringes, with or without needles, needles, blood and urine glucose test strips, ketone test strips and tabs) shall be limited to the lesser of: • The quantity prescribed in the Prescription Order or Refill; or • A 31day supply as defined by the Health Plan; or • The quantity limit set by Us for a specific drug; or • The amount necessary to provide a [30-31] day supply according to the maximum dosage approved by the Food and Drug Administration for the indication for which the drug was prescribed; or • One (1) vial of insulin; or • One (1) commercially prepackaged set of syringes, test strips, tablets, capsules, lancets or other supply. The quantity of Maintenance Drugs obtained through a Mail Order shall be limited to the lesser of: • The quantity prescribed in the Prescription Order or Refill; or • A 90-day supply as defined by Us. Member shall pay: (a) three (3) Copayments per 90-day supply Prescription Order or Refill; or (b) for commercially prepackaged drugs, such as topicals, inhalers and vials, one (1) Copayment for each package or unit.
Preventive Services	Covered Service. Medically Necessary preventive services as defined under PPACA, including: • Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force; • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; • With respect to infants, children and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and With respect to women, such additional preventive care and screenings not described in bullet point one as provided for in comprehensive guidelines supported by the

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
	Health Resources and Services Administration.
Prosthetics	Covered Service. Prosthetic devices, which replace an external body part and are utilized for a specific patient and not otherwise excluded, are Covered when Medically Necessary. Testicular Prostheses is considered Medically Necessary for replacement of congenitally absent testes, or testes lost due to disease, injury, or surgery.
Pulmonary Rehabilitation Therapy (Outpatient)	Covered Service.
Radiation Therapy	Covered Service.
Radiology	Covered Service.
Reconstructive Surgery	Covered Service for: 1. Surgery and associated services to repair disfigurement resulting from an injury. 2. Surgery to correct significant defects from congenital causes (except where specifically excluded. 3. Services associated with Reconstructive Surgery necessary to correct disfigurement incidental to a previous surgery. 4. Services associated with a surgery that substantially improves functioning of any malformed body part, unless specifically Excluded elsewhere in this Contract.
Short-Term Therapies: ~ **Occupational Therapy** ~ **Physical Therapy** ~ **Speech Therapy**	Covered Service. Please refer to Your Schedule of Benefits for possible limitations.
Skilled Nursing Facility	Covered Service when deemed Medically Necessary by the Health Plan in lieu of Hospitalization. Please refer to Your Schedule of Benefits for possible limitations.
Spinal Manipulation	Covered Service
Transplants	Covered Service, as follows: 1. Services related to Medically Necessary organ transplants if the Covered transplant Services are performed at a Coventry Transplant Network Facility. 2. Donor screening tests when the testing is performed at a Coventry Transplant Network Facility. 3. If the donor is not covered by any other source, the cost of any care, including complications, arising from an organ donation by a non-covered individual

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
	when the recipient is a Covered Member will be covered for the duration of the Contract of the Covered Member. 4. Travel expenses for Members and living donors are covered according to Our transplant travel benefit, as long as CHL is the primary insurer and a Coventry Transplant Network Facility is used. 5. In order to be Covered, Transplants must be rendered by a Coventry Transplant Network Facility. **Transplants that are provided at a non-Coventry Transplant Network Facility, even if the non-Coventry Transplant Network Facility is a Participating Provider, are *not* covered.**
Urgent Care	Covered Service. Covered Urgent Care for an unexpected illness or injury that does not qualify as an Emergency but requires prompt medical attention. Urgent Care Services are covered whether provided by Participating or Non-Participating Providers.

SECTION 6
EXCLUSIONS AND LIMITATIONS

The Health Plan does not cover the items listed below. In the event of any conflict between the list of Exclusions and limitations set forth below and the Covered Services list above, the list of Exclusions and limitations shall govern.

6.1 The Health Plan does not cover the following items:

1. [Any service or supply rendered by a Specialist and for which a PCP referral is required, except that Emergency Services, obstetrical and gynecological care from an In-Network Provider and mental health and substance abuse services from an In-Network Provider that are otherwise Covered Services shall be covered in accordance with the terms and conditions set forth in the Contract regardless of whether a PCP referral is obtained];

2. Any service or supply that is not Medically Necessary;

3. Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-covered service;

4. Any service or supply for which You have no financial liability or that was provided at no charge;

5. Non-Emergency Services provided outside the Service Area, including elective care, obstetrical services [after 37 weeks of pregnancy], follow-up care of an illness or injury, or care required as a result of circumstances that could have been reasonably foreseen by You before leaving the Service Area.

6. Procedures and treatments that We determine, in Our sole and absolute discretion to be Experimental or Investigational.

7. Services and or supplies rendered as a result of injuries sustained during the commission of an illegal act;

8. Court-ordered services or services that are a condition of probation or parole;

9. Any service or supply for which Health Plan has not received or for which Health Plan has not received from a Health Insurance Marketplace, confirmation of Member's eligibility; and

10. Any service for which a Prior Authorization is required and is not obtained.

11. Treatment, services, and supplies for an Injury are not Covered when a contributing cause was Your illegal or excessive use of alcohol, including driving while under the influence of alcohol. A police officer's or treating Provider's determination that You were functioning under the influence of illegal or excessive use of alcohol when the Injury was sustained will be sufficient evidence for this Exclusion to apply.

12. Treatment, services, and supplies for an Injury are not Covered when a contributing cause was Your voluntary taking of or being under the influence of an intoxicant or narcotic that was not taken or administered on the advice of a Physician, including driving while under the influence of such intoxicant or narcotic. A police officer's or treating Provider's determination that You were functioning under the influence of such intoxicant or narcotic when the Injury was sustained will be sufficient evidence for this Exclusion to apply.

13. Treatment, services, and supplies required to treat an Injury or illness that was directly or indirectly caused by an intentional or negligent action by You are not Covered, unless such Injury or illness is the direct result of an act of domestic violence or a medical condition.

14. Any medical service that is directly or indirectly the result of receiving a Non-Covered Service, procedure, Prescription Drug, medicine, equipment, or supply, including any associated complications, is Excluded from Coverage.

15. We Exclude from Coverage any charges that are in excess of Your Benefit Maximum, as described in Your Schedule of Benefits.

6.2 Specifically Excluded Services include but are not limited to (this is not an exhaustive list):

1. Abortion services and supplies, except in the cases where (i) a Member suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a Physician, place the Member in danger of death unless an abortion is performed or (ii) the pregnancy is the result of an act of rape or incest.

2. Acupuncture & Acupressure - Acupuncture and acupressure services.

3. Alopecia - Alopecia treatment, including the treatment of age-related hair loss.

4. Alternative Therapy- Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to: acupressure, acupuncture, aroma therapy, behavior modification, behavior training, biofeedback, colonic therapy, dietary products, educational therapy, gambling therapy, hair analysis, herbal therapy, hippo therapy, holistic medicine, homeopathy, hypnotherapy, massage therapy, music therapy, naturopathy; prolotherapy; prolozone therapy, recreational therapy (e.g. dance, music, arts, crafts, aquatic), sleep therapy, Vax-D therapy, and vitamin therapy except as outlined in the Schedule of Covered Services.

5. Ambulance service except as outlined in the Schedule of Covered Services.

6. Any services to the extent that payment for such services is, by law, covered by any governmental agency as a primary Plan.

7. Augmentative Communication Devices, including but not limited to devices utilizing word processing software and voice recognition software.

8. Behavior modification, behavioral or educational disorder services and associated expenses related to confirmation of diagnosis, progress, staging or treatment of behavioral (conduct) problems, ADD, Oppositional Defiant Disorder, learning disabilities.

9. Biofeedback- All biofeedback services and supplies related thereto.

10. Blood Storage - Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, umbilical cord blood harvesting and storage is not a Covered Service.

11. Braces and supports needed for athletic participation including but not limited to school-related athletic activity, or employment.

12. Care Rendered to You by a Relative - Services or supplies provided by an immediate family member or relative, and services or supplies provided by a person who ordinarily resides in a Member's household.

13. Charges by providers for failure to appropriately cancel a scheduled appointment, telephone calls, completion of forms, transfer of records, copying of medical records or generation of correspondence, or annual or monthly administrative fees.

14. Complications from Non-Compliance - Non-emergent services for treatment of complications that

occurred because You did not follow the course of treatment prescribed by a Provider.

15. Corrective Appliances - Corrective appliances used primarily for Cosmetic purposes, including but not limited to cranial prostheses and molding helmets. Except as specified in the Schedule of Covered Services, replacement Coverage for Covered Corrective Appliances is limited to once every two (2) years for irreparable damage and/or normal wear, or a significant change in medical condition.

16. Cosmetic Services and Treatments - Those Services, associated expenses, or complications resulting from Cosmetic Surgery and Services. Cosmetic procedures or treatments include, but are not limited to, treatment for alopecia, blepharoplasty, panniculectomy, pharmacological regimens, plastic surgery, treatment for varicose veins (unless Member is diabetic or has peripheral vascular disease), and non-Medically Necessary dermatological procedures and non-Medically Necessary Reconstructive Surgery. Breast reconstruction following a Medically Necessary mastectomy is not considered Cosmetic and is a Covered Service.

17. Counseling Services and Associated Therapies - Counseling and associated therapies including, but not limited to educational; learning disorder; marriage or relationship; vocational or employment; religious; and sexual disorders/relationship.

18. Custodial Care - Care is considered custodial when it is primarily for meeting personal needs. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, shopping, eating and preparing meals, performing general household services, taking medicine, ventilator dependent care or furnishing other home services mainly to help people in meeting personal, family, or domestic needs to include extraordinary personal needs created by the illness of a Dependent. Custodial care is Excluded regardless of the location or setting. Custodial care includes, but not limited to: care rendered in a boarding home, domiciliary care, long term care, nursing home care, protective care, rest cures and supportive care, and all services related thereto.

19. Dental - Dental care; dental Reconstructive Surgery; dental appliances; dental implants; dentures; dental x-rays including any services or X-ray examinations involving one or more teeth (natural and artificial), the tissue or structure around them, the alveolar process, or the gums; treatment of missing, malpositioned or supernumerary teeth, even if part of congenital anomaly; dental prosthetics; removal of dentiginous cysts, mandibular tori, and odontoid cysts; removal of teeth as a complication of radionecrosis or to prevent systemic infection.

20. Disposable Supplies - Supplies, equipment or personal convenience items including, but not limited to, combs, lotions, bandages, alcohol pads, incontinence pads, surgical face masks, common first-aid supplies, disposable sheets and bags, except for those disposable supplies that are Medically Necessary and outlined in the Covered Services Section above.

21. Durable Medical Equipment (DME) – a. Charges exceeding the total cost of the Maximum Allowable Charge to purchase equipment, if applicable. b. Unnecessary repair, adjustment, or replacement, or duplicates of any such equipment. c. Supplies and accessories that are not necessary for the effective functioning of the Covered equipment. d. Items to replace those that were lost or stolen or prescribed as a result of new technology. e. Items that require or are dependent on alteration of home, workplace, or transportation vehicle. f. Motorized scooters, exercise equipment, hot tubs, pool, saunas. g. Deluxe or enhanced equipment. The most basic equipment that will provide the needed medical care will determine the benefit. h. computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, and seat lifts of any kind. i. Patient lifts, auto tilt charis, air fluidized beds, or air flotation beds, unless approved by Case Management for a Member who is in Case management. J. Portable ramp for a wheelchair. Replacement resulting from malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Member are NOT Covered. There is also no Coverage for replacement of the equipment, device or appliance if the Member is non-compliant with its use as prescribed by the Member's Physician.

22. DME Repair and/or Maintenance - Repair and maintenance for routine servicing such as testing, cleaning, regulating and checking of equipment is not Covered except as specified in the Schedule of Covered Services. Except as specified in the Schedule of Covered Services, repair Coverage is limited to but not inclusive of, adjustment required by wear or by condition change (other than excessive weight gain not related to normal growth patterns in children) when prescribed by a Provider, repairs necessary to make the equipment/appliance serviceable unless the repair cost exceeds the cost of the equipment/appliance.

23. Educational Testing or Educational Services - Those educational services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training.

24. Elective or Voluntary - Those elective or voluntary enhancement procedures, services, and medications (such as testosterone or growth hormone) for purposes, including but not limited to: acne; hair growth; sexual performance; athletic performance; Cosmetic purposes; anti-aging; mental performance; weight loss; Sal abrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition, services performed for the treatment of a scar, even when the medical or surgical treatment has been provided by the Health Plan for the condition resulting in the scar, are not Covered.

25. Exercise equipment, including but not limited to a swimming or therapy pool.

26. Eye examinations, Eye exercises, Eye surgery, Vision aids and Appliances and Vision Therapy - Those health services and associated expenses for examinations to determine the need for or change in prescription or other examination related to wearing eyeglasses or lenses of any type; training or orthoptics, including eye exercises (also referred to as vision therapy or eye training); optometric services; eye surgery, including but not limited to: blepharoplasty, refractive surgery, radial keratotomy, laser corneal resurfacing, LASIK, myopic keratomileusis or other surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring); eyeglasses and contact lenses, including but not limited to prescription inserts for diving masks or other protective eyewear; nonstandard items for lenses including tinting and blending. This exclusion does not apply to: (1) the first pair of contact lenses or eyeglasses following the initial diagnosis of aphakia or the surgical removal or surgical replacement of an organic lens; or 2) hydrophilic contact lenses used as a corneal bandage to treat conditions involving the cornea. Notwithstanding the foregoing, this provision shall not apply to those Pediatric Vision benefits that are Covered Services, as set forth in the “Covered Services” Section of this Contract.

27. Family Planning and Reproductive Services- (a) Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to: (1) artificial insemination; (2) in vitro fertilization; (3) fallopian tube reconstruction; (4) uterine reconstruction; (5) assisted reproductive technology (ART) including but not limited to GIFT and ZIFT; (6) fertility injections; (7) fertility drugs, (8) services for follow-up care related to infertility treatments. (b) Services or supplies for the reversals of sterilizations. (c.) Induced abortion unless: (1) the health care Provider certifies in writing that the pregnancy would (1)endanger the life of the mother, or; (2) the fetus is not viable.

28. Food or Food Supplements and Medical Foods - The cost of outpatient enteral tube feedings, nutritional formula or supplements and supplies, regardless of whether such supplements/foods are the sole source of nutrition, except for low protein foods as described in the Covered Services Section above. Additionally there is no coverage for donor breast milk or the treatment of eating disorders, including, but not limited to anorexia or bulimia.

29. Foot Care - Routine foot care such as removal or reduction of corns and calluses, clipping of nails, treatment of flat feet or fallen arches, arch supports, orthotics, treatment of chronic foot strain, medical or surgical treatment of onychomycosis (nail fungus), trimming of hyper keratotoic lesions,

corrective shoes, shoe inserts, heel elevations, treatment of weak, strained, flat, unstable, or unbalanced feet, treatment of metatarsalgia, and removal of toenails except Medically Necessary surgery for ingrown toenails and routine foot care and orthotics required to treat manifestations of systemic disease causing circulatory problems, such as diabetes or peripheral vascular disease (PVD).

30. Gender Reassignment - Studies, treatments or procedures for sex transformation or sexual identification.

31. Growth Hormone - Growth hormone therapy for any condition or idiopathic short stature, except children less than 18 years of age who have been appropriately diagnosed to have a documented growth hormone deficiency or individuals with Turner's syndrome or HIV wasting syndrome.

32. Hair analysis, wigs and hair transplants.

33. Hearing Services - Includes but not limited to cochlear implants, hearing aids(except for hearing aids covered for children up to the age of eighteen (18) as described above),in the "Covered Services" section of this Contract other hearing implants, audiometric testing associated with these devices and other hearing devices, tinnitus maskers, and any related purchases, adjustments, or services.

34. Home services to help meet personal/family/domestic needs - Services or related to help meet personal, family, and/or domestic needs, including, but not limited to, Home Health aids, activities of daily living such as bathing, dressing, eating and preparing meals, shopping, performing general household services, and taking medication.

35. Hypnotherapy - Therapy undertaken while the Member is in hypnosis.

36. Immunizations and Examinations - Examinations or immunizations for employment, travel, school, camp, sports, licensing, insurance, adoption, marriage or those ordered by a third party.

37. Infertility services and supplies - Any medical service, office visit, lab, diagnostic test, prescription drug, equipment, medicine, supply, or procedure directly or indirectly related to promoting conception by artificial means including but not limited to: artificial insemination (AI);, artificial reproductive technology (ART); egg or sperm donation; egg, ovum or sperm harvest; embryo transplants; intracytoplasmic sperm injection (ICSI); in vitro and in vivo fertilization (IVF) which includes gamete intrafallopian transfer (GIFT) and zamete intrafallopian tube transfer (ZIFT) procedures; selective reduction, cryopreservation and storage of sperm, eggs and embryos; supplies and drug therapies including but not limited human chorionotropin, urofollitropin, menotropins or derivatives; drugs and travel cost for selective reduction, related cost of sperm and egg collection and preparation; non-Medically Necessary amniocentesis; Hospitalizations due to complications of infertility therapies or drugs; and any Infertility treatment deemed Experimental or Investigational.

38. Medical Appliances, Devices, Medical Equipment, or Services - Appliances, devices, equipment, or services including but not limited to equipment that alters air quality or temperature air conditioners; athletic equipment; bathtub assistive devices; batteries and battery chargers; bed-liners; canes; cervical collars; corsets; cranial helmets; dehumidifiers; elastic or leather braces or supports; emergency alert equipment; exercise equipment; expenses incurred at a health spa, gym or similar Facility; filters; grab/tub bars; guest meals and accommodations; heating pads; home improvement items; including but not limited to: escalators, elevators, ramps, stair glides, humidifiers, office chairs; office visits for a non-covered device or supply; mattress covers; rental or purchase of TENS units, sun or heat lamps; take home medications and supplies; traction apparatus; tub benches; telephone; television; wheelchair lifts; and whirlpool baths.

39. Newborn home delivery.

40. Over-the-counter supplies such as ACE wraps/elastic supports/finger splints, orthotics, orthopedic splints, knee braces.

41. Oral Surgery - Except as specified in the "Covered Services" section of this contract, oral and dental surgery and related services and supplies including: orthodontics, periodontics, endodontics, prosthodontics, and preventive, Cosmetic or restorative dentistry, including services and supplies for treatment of congenital abnormalities. Services required as part of an orthodontic treatment program or required for correction of an occlusal defect, including but not limited to removal of symptomatic bony impacted third molars.

42. Temporal mandibular joint surgery or other oral surgery services Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) tooth extraction; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth. b. Treatment for correction of underbite, overbite, and misalignment of the teeth including braces for dental indications.

43. Orthodontia and related services.

44. Pediatric Vision:
    a. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
    b. Medical and/or surgical treatment of the eye, eyes or supporting structures;
    c. Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; including but not limited to industrial or safety glasses.
    d. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
    e. Plano (non-prescription) lenses and/or contact lenses;
    f. Non-prescription sunglasses;
    g. Two pair of glasses in lieu of bifocals;
    h. Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.
    i. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.
    j. Services or materials rendered by a Provider other than an Ophthalmologist, Optometrist, or Optician acting within the scope of his or her license.
    k. Any additional service required outside basic vision analyses for contact lenses, except fitting fees.
    l. Services rendered or materials ordered before the date coverage began under the Covered Policy.
    m. Regardless of Optical Necessity, benefits are not available more frequently than that which is specified.
    n. Allowances are one-time use benefits; no remaining balance.
    o. Discounts do not apply for benefits provided by other benefit Plans.

45. Phase I and II clinical trials for the treatment of cancer.

46. Phase I, II, III, and IV clinical trials for the treatment of diagnoses other than cancer.

47. Psychiatric evaluation or therapy - When related to judicial or administrative proceedings or orders, when employer requested, or when required for school.

48. Psychological testing - Testing including but not limited to the treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders, and behavioral training.

49. Physiotherapy Services - Physiotherapy services (occupational, physical and speech) for psychosocial and/or developmental delays, including, but not limited to mental retardation, cerebral palsy, chronic brain injury, or speech therapy for stuttering. Physiotherapy services (occupational, physical and speech) for work hardening or for recreational purposes, including, but not limited to sports or vocal performance and Services related to the treatment of sensory processing dysfunction or sensory integration disorder. This exclusion does not apply to the initial assessment for diagnosis of the condition or to the medical management of an underlying medical illness which may be contribution to the condition.

50. Private duty nursing.

51. Private inpatient room, unless Medically Necessary or if a semi-private room is unavailable.

52. Personal comfort and convenience items such as television and telephone.

53. Prosthetic - a. Hearing aids for Members age 18 or older; b. prosthetics primarily for Cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants; c. items to replace those that were lost, damaged, stolen, or prescribed as a result of new technology; d. the replacement of contacts after the initial pair have been provided following cataract surgery; e. foot orthotics, shoe inserts, and custom made shoes except as required by law for diabetic patients or as part of a leg brace, and f. penile prosthesis.

54. Robotics - Services performed by robotic equipment.

55. Sterilization reversal.

56. Substance Abuse - substance abuse maintenance therapy such as methadone therapy, and similar drug therapies including clinical and professional services provided specifically for such therapies. Medically Necessary detoxification or Medically Necessary Rehabilitation Services are Covered. Please see Your Schedule of Benefits for limitations.

57. Surgery performed solely to address psychological or emotional factors.

58. Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of a Member acting as a surrogate mother.

59. Transplant Services, screening tests, and any related conditions or complications related to organ donation when a Member is donating organ or tissue to a non-Member.

60. Transplant Services and associated expenses involving temporary or permanent mechanical or animal organs.

61. Travel Expenses - Travel or transportation expenses, even though prescribed by a Provider, except as specified in the Covered Services Section.

62. Treatment of sexual dysfunction - Treatment, services, devices, and supplies related to sexual

dysfunction. This exclusion does not apply to implantation of a penile prosthesis or use of an external device for impotence caused by an organic disease such as diabetes mellitus or hypertension, or caused by surgery for genitourinary cancer.

63. Treatment of mental retardation, unless Covered as a biologically-based mental illness.

64. Treatment for disorders relating to learning, motor skills, communication, and pervasive developmental conditions such as autism, augmentative communication devices, including but not limited to devices utilizing word processing software and voice recognition software.

65. Varicose Veins - Treatment for varicose veins, including but not limited to micro-surgery and laser therapy. The treatment of varicose veins for complications related diabetes and peripheral vascular disease are covered if Medical Necessary.

66. Vocational therapy- Therapy to enable the disabled individual to resume productive employment.

67. War related sickness, injury, services or care for military service-connected disabilities and conditions for which You are legally entitled to Veteran's Administration services and for which facilities are reasonably accessible to You.

68. Services for conditions resulting from war or acts of war.

69. Weight reduction therapy, supplies and services, including but not limited to diet programs, tests, examinations or services and medical or surgical treatments such as intestinal bypass surgery, stomach stapling, balloon dilation, wiring of the jaw and other procedures of a similar nature, except where We determine them to be Medically Necessary.

70. Work hardening programs.

71. Work related injuries or illnesses, including those injuries that arise out of or in any way result from an illness or injury that is work-related, provided the employer provides, or is required to provide, workers' compensation or similar type coverage for such services.

6.3 In addition to the Exclusions and limitations set forth in Sections 6.1 and 6.2, above, the following Exclusions and limitations also apply to outpatient Prescription Drugs.

Limitations:

Prior Authorization. Some Prescription Drugs or Specialty Drugs require Prior Authorization in order to be Covered under Your Prescription Drug benefits. These include, but are not limited to, medications that may require special medical tests before use or that are not recommended as a first-line treatment or that have a potential for misuse or abuse. Drugs requiring Prior Authorization are identified in the Formulary with "PA" next to the name of the drug. Before You can receive Coverage for a Prescription Drug or Specialty Drugs requiring Prior Authorization, the Prescribing Provider must first contact Us Plan by phone, fax or electronic communication in order to obtain, and You must be granted Prior Authorization by Us. For those Drugs requiring Prior Authorization, Coverage for Your Prescription Drug or Specialty Drugs will be delayed until Prior Authorization has been requested from and approval provided by Us.

Step Therapy. Some Prescription Drugs or Specialty Drugs require Step Therapy in order to be Covered under Your Prescription Drug benefits. These include, but are not limited to, medications that are not recommended as a first-line treatment. Drugs requiring Step Therapy are identified in the Formulary with "ST" next to the name of the drug. If when the Participating Pharmacy submits a claim via the online system and the claim is returned to the Participating Pharmacy because it does not find a required first-line treatment in Your claim history, then the Prescribing Provider must obtain Prior Authorization from Us in order for the drug to be Covered.

Specific Quantity Limits. Some Prescription Drugs are subject to specific quantity limits. You can obtain information on specific quantity limits from the searchable Formulary on Our website or by contacting Our Customer Service Department.

Authorized Refills will be provided for the lesser of:

i) twelve (12) months from the original date on the Prescription Order unless limited by state or federal law; or

ii) the number of Refills indicated by the Prescribing Provider.

Coordination of Benefits. There is no coordination of benefits for Your Prescription Drug coverage with other Health Plans except for Medicare Parts B and D. This means that if You have primary drug coverage with another Plan, We do not cover under this Contract the portion of Your Prescription Drug coverage remaining after Your primary coverage has paid.

Coverage of injectable drugs is limited to Self-Administered Injectable Drugs and injectable diabetes agents, bee sting kits, injectable migraine agents and injectable contraceptives that are commonly and customarily administered by the Member.

Except in a Medical Emergency, Self-Administered Injectable Drugs and Specialty Medications are available only from a Specialty Pharmacy unless otherwise Prior Authorized by Us.

We reserve the right to include only one (1) manufacturer's product on the Formulary when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers. The product that is listed on the Formulary will be covered at the applicable Copayment, Deductible or Coinsurance. The product or products not listed on the Formulary will be Excluded from coverage.

We reserve the right to include only one (1) dosage or form of a drug on the Formulary when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms (for example but not limitation, dissolvable tablets, capsules, etc.) from the same or different manufacturers. The product in the dosage or form that is listed on the Formulary will be covered at the applicable Copayment, Coinsurance and/or Deductible. The product or products in other forms or dosages that are not listed on the Formulary will be Excluded from coverage.

Coverage of therapeutic devices or supplies requiring a Prescription Order and prescribed by a prescribing Provider is limited to Plan-approved diabetic test strips and lancets, and contraceptive diaphragms.

Plan-approved blood glucose meters, asthma holding chambers and peak flow meters are Covered Drugs, but are limited to one (1) Prescription Order per year.

Coverage through the Mail Order Pharmacy is not available for drugs that are not Maintenance Drugs as defined by Us, drugs that cannot be shipped by mail due to state or federal laws or regulations, or when We or the Mail Order Pharmacy consider shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, all controlled substances, and anticoagulants.

We reserve the right to limit the location at which You can fill a Covered Drug to a Participating Pharmacy that is mutually agreeable to both the Us and You. Such limitations may be enforced in the event that We identify an unusual pattern of claims for Covered Drugs.

Certain vaccines are Covered when obtained and administered in a Participating Pharmacy by a certified professional. These vaccinations are noted as such in the Formulary.

Other Limitations include the following:

- The number of doses of a Prescription Drug that is Covered during the last two (2) months of this Contract or departure for active military duty may be limited to an amount sufficient to last only until the termination of the Contract.

- Pharmacy shall not dispense and We will not Cover a Prescription Drug order which, in the Pharmacist's professional judgment, should not be filled. For example, a pharmacist may refuse to fill a prescription if he or she believes that filling the prescription is not in the best interest of Your health, may interact badly with another drug You are taking, that an excessive quantity has been prescribed or that the prescription is incomplete or was not issued by the Prescribing Provider whose name appears on the prescription.

- Early fills for vacation or travel out of the country are limited to [once][twice] per calendar year. These early fills are limited to a 30 day supply. Early Refills on controlled substances are not allowed.

- We reserve the right to include only one (1) manufacturer's brand name product on Our Formulary when the same or similar drug (i.e., a drug with the same active ingredient), supply or equipment is made by two (2) or more different brand name drug manufacturers. The product that is listed on Our Formulary will be Covered at the applicable Co-payment level. The product or products of the same drug not listed on the Formulary will be Excluded from Coverage.

- We reserve the right to include only one (1) dosage or form of a drug on Our Formulary when the same drug (i.e., a drug with the same active ingredient) is available in different dosages or forms (i.e., dissolvable tablets, capsules, etc.) from the same or different manufacturers. The product, in the dosage or form that is listed on the Formulary will be Covered at the applicable Co-Payment level. The product or products, in different forms or dosages, not listed on the Formulary will be Excluded from Coverage.

- Maintenance Drugs may only be Covered when dispensed by the Mail Order Pharmacy as described in the Prescription Drugs Section of the Schedule of Covered Services, above.

Exclusions:

The cost of the following Prescription Drugs and products is specifically Excluded from Coverage provided under Your Prescription Drug benefits and is not Covered, **even if** prescribed by a Prescribing Provider and dispensed at a Participating Pharmacy:

1. Any Prescription Drugs, injectables, supplies, devices or other items covered under the Medical Benefit.

2. Prescription Drugs dispensed by Non-Participating Pharmacies, except as described in the ***Limitations*** Section, above.

3. Prescription Drugs not listed in the Formulary, unless the Participating Provider, for valid medical reasons, requests and receives Plan approval in advance of ordering a non-Formulary drug.

4. Drugs and products: (i) from which no significant improvements in physiologic function could be reasonably expected; or (ii) that do not meaningfully promote the proper function of the body or prevent or treat illness or disease; or (iii) is done primarily to improve the appearance or diminish an undesired appearance of any portion of the body. These include but are not limited to, drugs prescribed for the prevention of wrinkles, skin depigmentation or hair restoration or hair loss or drugs whose primary FDA indication is for Cosmetic use. Topical products used in conjunction with chemotherapy or radiation therapy such as but not limited to Biafine.

5. Devices or supplies of any type, even though requiring a Prescription Order unless otherwise specified as a Covered Benefit in Section 5. These include, but are not limited to therapeutic devices, support garments, corrective appliances, non-disposable hypodermic needles, or other devices, regardless of their intended use.

6. Drugs prescribed and administered, in whole or in part, in a Physician's office, medical office, Hospital, or other health care Facility.

7. Implantable time-released medication, including, but not limited to implantable contraceptives.

8. Drugs and products that do not, by federal or state law, require a prescription to be dispensed, such as aspirin, antacids, herbal products, oxygen, medicated soaps, and bandages, or Prescription Drugs with non-Prescription Drug alternatives or over-the counter equivalents (e.g., Benadryl 25 mg) even if prescribed in the generic form, unless as specifically noted in the Formulary.

9. Drugs, oral or injectable, used for the primary purpose of, or in connection with, treating Infertility, fertilization and/or artificial insemination.

10. Fluids, solutions, nutrients, or medication used or intended to be used by intravenous or gastrointestinal (enteral) infusion, or by intravenous injection in the home setting, except as specifically listed as a Covered Service in Section 5.

11. Experimental or Investigational drugs.

12. Growth hormones, except that they are Covered when used to treat a congenital anomaly such as but not limited to Turner's Syndrome.

13. Any Prescription Drug that is being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper; and drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Member identification card, including drugs obtained for use by anyone other than the Member identified on the identification card.

14. Drugs used for athletic performance enhancement or Cosmetic purposes, including, but not limited to anabolic steroids, tretinoin for aging skin, and minoxidil lotion.

15. Injectable medications [other than Self-Administered Injectables or Specialty Drugs defined in this Contract] as designated by Us, Glucagon, Insulin, Imitrex and bee sting kits; (refer to the Covered Services Section of this Contract for information regarding Coverage of injectables under Section 5).

16. Vitamins and minerals, both over-the-counter and legend, except legend prenatal vitamins for pregnant or nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium.

17. Oral dental preparations and fluoride rinses, except fluoride tablets or drops.

18. Refill prescriptions resulting from loss or theft, or resulting from damage by the Member.

19. Compounded prescriptions are Excluded unless all of the following apply:

    i) Except as Authorized by Us, there is no suitable commercially-available alternative available; and

    ii) the main active ingredient is a Covered Drug; and

iii) the purpose is solely to prepare a dose form that is Medically Necessary and is documented by the Prescribing Provider; and

iv) the claim is submitted electronically.

Compounded prescriptions whose only ingredients do not require a prescription are Excluded. Also Excluded are compounded prescriptions for which the major ingredient is not approved by the FDA for the intended use.

20. Prescriptions directly related to non-Covered Services.

21. Any drug or product which is being administered for preparation of or post operatively for sexual transformation and/or gender reassignment.

22. Progesterone for the treatment of premenstrual syndrome (PMS) and compounded natural hormone therapy replacement.

23. Drugs and products used primarily as a part of a smoking cessation program (e.g., oral drugs, Nicorette gum, nasal sprays, inhalers and nicotine patches).

24. The cost of special packaging required for drugs dispensed in nursing homes.

25. Drugs prescribed and taken for the purpose of facilitating travel, including, but not limited to, medications, devices and supplies for motion sickness or travel-related disease (e.g., Relief bands, vaccines).

SECTION 7
COMPLAINTS AND APPEALS

We maintain informal and formal procedures to resolve Member inquiries, Grievances, and Appeals. These processes give Members the opportunity to ask Us to review any matter related to Covered Services, including but not limited to:

- Issues about the scope of Coverage for Health Care Services;
- Denial, cancellation, or non-renewal of Coverage;
- Denial of care/services/claims;
- Member rights; and
- The quality of the Health Care Service received.

7.1 Appointing an Authorized Representative

Grievances and Appeals can be filed by You or Your Authorized Representative. In order to ensure compliance with federal and state privacy laws, We will require You to complete and return an Authorized Representative form before We will discuss any of Your confidential health or financial information with Your Authorized Representative. An Authorized Representative form can be obtained by contacting Us at **855-449-2889.**

7.2 Procedure for Filing a Grievance

If You are not satisfied with an action by Us, You have the right to file a Grievance. We consider all Grievances and will attempt to rectify the situation where appropriate. Grievances may be submitted via telephone by calling Our Customer Service Organization at **855-449-2889**or may be submitted in writing to the following address:

[Coventry Health and Life Insurance Company
Attention: Appeals Department
3838 N. Causeway Blvd.
Suite 3350
Metairie, Louisiana 70002]

7.3 Medical Necessity Denials

A **Medical Necessity Denial** is a medical determination where We denied, reduced, or terminated a treatment, service, or supply based on Medical Necessity, medical appropriateness, health care setting, level of care, or effectiveness.

A. Informal Peer-to-Peer Reconsideration

In the event that We issue a Medical Necessity Denial, We shall give the treating Provider an opportunity to request an informal peer-to-peer reconsideration. A request for a peer-to-peer reconsideration must be received within ten (10) calendar days of the initial denial. We will contact the treating Provider requesting the peer-to-peer reconsideration within one (1) business day of receiving the request.

B. Medical Necessity Appeals

A **Medical Necessity Appeal** is an Appeal of a Medical Necessity Denial, as defined above. There are three types of Medical Necessity Appeals:

- **Pre-Service Medical Necessity Appeals** are Medical Necessity Appeals for which We have denied Prior Authorization for a Covered Service and You are Appealing before the Covered Service has been rendered.

- **Expedited Pre-Service Medical Necessity Appeals** are a special type of Pre-Service Medical Necessity Appeal in which the Appeal must be reviewed in an expedited manner because a delay in review could seriously jeopardize: (a) the life or health of the Member; or (b) the Member's ability to regain maximum function. In determining whether an Appeal involves Urgent or Emergency Care (e.g. to screen and stabilize the patient) requiring expedited review, We will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. We will also review a Pre-Service Medical Necessity Appeal in an expedited manner when: (a) Your treating Physician deems the care to be Urgent in nature; or (b) Your treating Physician determines that delaying the care would subject You to severe pain that cannot be adequately managed without the care or treatment that is being requested. An expedited Appeal may be initiated by the Member with the consent of the treating Physician or by the Physician acting on behalf of the Member.

- **Post-Service Medical Necessity Appeals** are Medical Necessity Appeals for which We have denied a Covered Service and You are Appealing after the Covered Service has been rendered.

C. How To Submit a Medical Necessity Appeal

Members may submit a Medical Necessity Appeal request to Us by telephone, fax, or mail to the following address:

[Coventry Health and Life Insurance Company
Attention: Medical Necessity Appeals Department
3838 N. Causeway Blvd.
Suite 3350
Metairie, Louisiana 70002]
[855-449-2889]

A Medical Necessity Appeal request must include the following information.

- Patient name, identification number, address, phone number, and date of birth;
- Member name, identification number, address, phone number, and date of birth;
- Member's Authorized Representative's name, mailing address, phone number, and fax number (if Member has appointed an Authorized Representative);
- Provider/Facility name, address, phone number, and fax number;
- Dates of service under Appeal;
- Whether Your Medical Necessity Appeal is Pre- or Post-Service, and if Pre-Service, whether or not You believe Your Medical Necessity Appeal qualifies for Expedited treatment;
- Clear indication of the remedy or corrective action being sought and an explanation of why the Plan should "reverse" Our denial; and
- Documentation to establish the Medical Necessity of the Covered Service (e.g. any and all medical records related to Your Appeal, other information from Your treating Physician, scientific/medical research, etc.).

If You are submitting Your Appeal request by telephone, You have seven (7) calendar days from the date of this telephone request to mail Your documentation to Us, including any and all medical records related to Your Appeal.

You may also request - free of charge - copies of the documents, records, and other information relevant to the medical determination that resulted in Your Medical Necessity Denial.

Your written request for a Medical Necessity Appeal must be filed within one hundred and eighty (180) calendar days after the date that We send notice of the initial denial to You. Medical Necessity Appeal requests that are submitted after one hundred eighty (180) calendar days will not be considered.

D. First Level Medical Necessity Appeal

Our Medical Necessity Appeal process has two levels. The First Level Medical Necessity Appeal will be conducted by a licensed Physician. The Physician reviewing Your First Level Medical Necessity Appeal will be a person who was not involved in the initial denial and who is not a subordinate of the person who issued the initial denial.

The First Level Medical Necessity Appeal will consider all comments, documents and records submitted by You and Your treating Providers regardless of whether this information was submitted to Us at the time the initial denial was issued. You may request identification of any vocational or medical expert whose advice was obtained in connection with Your First Level Medical Necessity Appeal (as applicable).

- **Pre-Service Medical Necessity Appeal Decisions--** We will notify You in writing of a First Level Pre-Service Medical Necessity Appeal decision within five (5) business days from determination, and within thirty (30) calendar days of Our receipt of Your Appeal and supporting information.

- **Expedited Pre-Service Medical Necessity Appeal Decisions--** In situations involving Expedited Pre-Service Medical Necessity Appeals, We will verbally notify You of Our determination as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after Our receipt of Your Appeal and supporting information. Verbal notification will be followed by written confirmation within three (3) calendar days.

- **Post-Service Medical Necessity Appeal Decisions--** We will notify You in writing of a First Level Post-Service Medical Necessity Appeal decision five (5) business days from determination, and within thirty (30) calendar days of Our receipt of Your Appeal and supporting information.

E. Second Level Medical Necessity Appeal

If You are not satisfied with Your First Level Medical Necessity Appeal decision, You may Appeal Your case to the Second Level Medical Necessity Appeal Committee. The Second Level Medical Necessity Appeal Committee is composed of one (1) to three (3) senior managers. The Second Level Medical Necessity Appeal Committee will include at least one licensed health care professional in the same or similar Specialty as typically manages the treatment or service under review and who must concur with any denial by the Second Level Medical Necessity Appeal Committee. The Second Level Medical Necessity Appeal Committee will not include the Physician who issued the First Level Medical Necessity Appeal decision.

The Second Level Medical Necessity Appeal Committee will consider all comments, documents and records submitted by You and Your treating Providers for the First Level Medical Necessity Appeal, as well as any additional materials that You wish to submit for consideration by the Second Level Medical Necessity Appeal Committee. **In addition, You and/or Your Authorized Representative (as applicable) have the right to appear before the Second Level Medical Necessity Appeal Committee to present Your case to the Committee.** If You are unable to attend the Committee meeting in person, We will arrange for You to participate by conference call.

In order to obtain a Second Level Medical Necessity Appeal, You must submit a request by telephone, fax, or by mail to the following address:

[Coventry Health and Life Insurance Company
Attention: Medical Necessity Appeals Department
3838 N. Causeway Blvd.
Suite 3350
Metairie, Louisiana 70002]
[855-449-2889]

If You want to submit additional information for consideration by the Second Level Medical Necessity Appeal Committee that was not submitted as part of Your First Level Medical Necessity Appeal, You must include this information in Your request for a Second Level Medical Necessity Appeal. You may also request- free of charge- **copies of** the documents, records, and other information relevant to Your First Level Medical Necessity Appeal decision.

If You are not satisfied with the decision of the Second Level Medical Necessity Appeal Committee, You may pursue normal remedies of law, including the External Review process described below and Your rights under ERISA Section 502(a) as applicable.

- **Pre-Service Medical Necessity Appeal Decisions--** We will notify You in writing of a Second Level Pre-Service Medical Necessity Appeal decision within five (5) calendar days from determination and within thirty (30) calendar days of Our receipt of Your Appeal and supporting information.

- **Expedited Pre-Service Medical Necessity Appeal Decisions--** In situations involving Second Level Expedited Pre-Service Medical Necessity Appeals, We will verbally notify You of Our determination as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after Our receipt of Your initial Appeal and supporting information. Verbal notification will be followed by written confirmation within three (3) calendar days.

- **Post-Service Medical Necessity Appeal Decisions--** We will notify You in writing of a Second Level Post-Service Medical Necessity Appeal decision within five (5) calendar days from determination and within thirty (30) calendar days of Our receipt of Your Appeal and supporting information.

F. External Review

You have the right to request an **External Review** of a Medical Necessity Denial once You have completed Your First Level and Second Level Medical Necessity Appeals as long as Your treating Provider concurs With Your decision to pursue External Review. Your External Review will be conducted by an Independent Review Organization (“IRO”) that is licensed and regulated by the Louisiana Department of Insurance. The IRO shall also be accredited by a nationally recognized accrediting organization.

If You would like to request External Review by an IRO, You must submit a written request sent by fax or by mail to the following address:

[Coventry Health and Life Insurance Company
Attention: Medical Necessity Appeals Department
3838 N. Causeway Blvd.
Suite 3350
Metairie, Louisiana 70002]
[855-449-2889]

You must submit Your request to Us in writing within six (6) months after You receive Your Second Level Medical Necessity Appeal Committee decision. If Your request is eligible for external review,

Your request will be forwarded to an assigned IRO, along with a copy of the documentation and information that was considered by the Second Level Medical Necessity Appeal Committee and also notify You or Your representative of the right to submit additional information. The IRO will provide notice of its recommendation to Us in writing within forty-five (45) calendar days after the date that the IRO receives Your information from Us, and We will provide notice to You within 3 business days of receipt of the IRO's recommendation.

You may request an External Review prior to exhausting the second level of Appeal, if: i) You have an Emergency Medical Condition; or ii) We decide to waive the requirements for the First Level Medical Necessity Appeal, Second Level Medical Necessity Appeal, or both; iii) We have failed to comply with the requirements of the internal Appeals process unless such a failure does not cause, and is not likely to cause, prejudice or harm to the person filing the Appeal; or iv) You or Your representative simultaneously request an expedited internal Appeal and an expedited External Review.

Your treating Provider may request an expedited External Review in situations involving an Expedited Pre-Service Medical Necessity Appeal. Requests for an expedited External Review should be submitted to Us in writing. The IRO will respond to Your External Review request within seventy-two (72) hours from the time that the IRO receives Your information from Us.

7.4 Administrative Denials

A. An **Administrative Denial** is a determination that a health care treatment, service, or supply is not a Covered Service under the terms of Your benefit Plan. **Administrative Denials are not based on a medical determination.** For example, We will issue an Administrative Denial if You request a service that is listed under the Exclusions and Limitations Section of Your Contract of Coverage (Section 6 because these services are not Covered under the terms of Your insurance policy. Appeals challenging Our Out-of-Network payment rates or denials for lack of Prior Authorization will also be handled as Administrative Denials.

Administrative Denials are subject to only one level of review (an "Administrative Appeal"). There are two types of Administrative Appeals:

- **Pre-Service Administrative Appeals** are Administrative Appeals for which We have denied Prior Authorization for a Covered Service and You are Appealing before the Covered Service has been rendered.

- **Post-Service Administrative Appeals** are Administrative Appeals for which We have denied a Covered Service and You are Appealing after the service has been rendered.

In order to request an Administrative Appeal, You may submit a request to Us by telephone, fax, or by mail to the following:

[Coventry Health and Life Insurance Company
Attention: Administrative Appeals Department
3838 N. Causeway Blvd.
Suite 3350
Metairie, Louisiana 70002]
[855-449-2889]

An Administrative Appeal request must include the following information:

- Patient name, identification number, address, phone number, and date of birth
- Member name, identification number, address, phone number, and date of birth;
- Member's Authorized Representative's name, mailing address, phone number, and fax number (if Member has appointed an Authorized Representative);

- Provider/Facility name, address, phone number, and fax number;
- Dates of service under Appeal;
- Whether Your Administrative Appeal is Pre- or Post-Service, and if Pre-Service, whether or not You believe Your Appeal qualifies for Expedited treatment;
- Clear indication of the remedy or corrective action being sought and an explanation of why We should "reverse" Our denial; and Documentation to support the reversal of Our decision (including any and all medical records related to the service under review).

If You are submitting Your request for an Administrative Appeal by telephone, You have seven (7) calendar days from the date of this telephone request to mail Your documentation to Us.

You may also request, free of charge, copies of the documents, records, and other information relevant to Your Administrative Denial.

Administrative Appeal requests must be filed within one hundred eighty (180) calendar days after the initial notice of denial has been sent to the Member. **Administrative Appeal requests that are received after one hundred eighty (180) calendar days will not be processed.** Administrative Appeals will be presented to the Administrative Appeal Committee, which consists of one (1) to three (3) senior managers of the Plan who were not involved in the original denial. Administrative Appeals do not involve an in-person or telephonic hearing.

- **Pre-Service Administrative Appeal Decisions--** We will notify You in writing of a Pre-Service Administrative Appeal decision within five (5) business days from determination and within thirty (30) calendar days of Our receipt of Your Appeal and supporting documentation.

- **Post-Service Administrative Appeal Decisions –** We will notify You in writing of a Post-Service Administrative Appeal decision within five (5) business days from determination and within sixty (60) calendar days of Our receipt of Your Appeal and supporting documentation.

If You are not satisfied with the decision of the Administrative Appeal Committee, You may have the right to bring civil action under ERISA Section 502(a).

B. Administrative Denials Involving a Law Enforcement Investigation

In the event that You obtain an Injury or Illness as a result of Your involvement in an incident or accident that is under investigation by the police or other law enforcement officials, We will request a copy of the incident or accident report from the applicable law enforcement offices, as well as copies of all of Your medical records related to the Injury or Illness. If all or a portion of the accident or incident report has not been released at the time of Your Administrative Appeal (including alcohol and toxicology reports as applicable), We will make the decision to approve or deny payment of Your claims based on the information that is accessible to Us at that time. However, please be advised that We may re-open Our decision at a later date if new material information becomes available to Us, such as an official investigation report, alcohol or toxicology test results, or medical records that were not accessible to Us on the date of Your Administrative Appeal. In the event that We make a different benefit determination based on this new material information, You will be given the right to another Administrative Appeal. Please be advised that We reserve the right to rely on the content of an official accident or incident report in making Our benefit determination (including alcohol and toxicology test results as applicable), regardless of whether criminal charges are ultimately pursued by the government or a conviction actually occurs.

If We discover that You or Your Authorized Representative intentionally withheld material information and/or materially misrepresented information related to Your Injury or Illness during Your Administrative Appeal, We may initiate a fraud investigation, which could result in the termination of Your Health Insurance Coverage.

7.5 Appeals Regarding Loss of Eligibility Due to Non-Payment of Premium

All Appeals regarding loss of eligibility due to non-payment of Premium must be submitted to the Health Insurance Marketplace, not CHL. Pursuant to federal regulation, all such Appeals shall be determined by the Health Insurance Marketplace.

7.6 Appeals Regarding Advance Premium Tax Credit

All Appeals relating to advance Premium tax credit, including but not limited to eligibility for such credit or the proper amount of such credit, must be submitted to the Exchange, not CHL. Pursuant to federal regulation, all such Appeals shall be determined by the Health Insurance Market.

SECTION 8
CONFIDENTIALITY OF YOUR HEALTH INFORMATION

We work hard to keep Your personal health information secure and private. You will receive a copy of Our Notice of Privacy Practices upon Your enrollment. This notice fully explains how We may use and share Your information. The notice is posted on Our web site at www.chctn.com, and You can also request another copy by calling Customer Service at **855-449-2889**. In general, We can access and disclose Your records and medical information as permitted under the privacy regulations set forth at 45 C.F.R. Part 164 and promulgated pursuant to the Federal Health Insurance Portability and Accountability Act of 1996.

Genetic Testing. In the event that We receive information derived from genetic testing that You have undergone, We agree not to use this information for any non-therapeutic purpose. We further agree not to release this information to any third party without Your explicit written consent.

SECTION 9
RIGHT OF RECOVERY

TENNESSEE
Right of Recovery

As used herein, the term "Third Party", means any party that is, or may be, or is claimed to be responsible for illness or injuries to You. Such illness or injuries are referred to as "Third Party Injuries." "Third Party" includes any party responsible for payment of expenses associated with the care of treatment of Third Party Injuries.

If this Plan pays benefits under this Contract to You for expenses incurred due to Third Party Injuries, then the Plan retains the right to repayment of the full cost of all benefits provided by this Plan on behalf of You that are associated with the Third Party Injuries. The Plan's rights of recovery apply to any recoveries made by, or on behalf of, You from the following sources including, but not limited to:

- Payments made by a Third Party or any insurance company on behalf of the Third Party;
- Any payments or awards under an uninsured or underinsured motorist Coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments Coverage under any automobile policy, premises, or homeowners' medical payments Coverage or premises or homeowners' insurance Coverage; and
- Any other payments from a source intended to compensate You for medical expenses arising from Third Party injuries.

By accepting benefits under this Plan, You specifically acknowledge the Plan's right of subrogation. When the Plan pays health care benefits for expenses incurred due to Third Party Injuries, the Plan shall be subrogated to Your rights of recovery against any party to the extent of the full cost of all benefits provided by this Plan. The Plan will notify You or Your representative of its interest and maintain contact throughout the process.

By accepting benefits under this Plan, You also specifically acknowledge the Plan's right of reimbursement. This right of reimbursement attaches when this Plan has paid health care benefits for expenses incurred due to Third Party Injuries and You or Your representative has recovered any amounts from a Third Party or the sources outlined above. The Plan's right of reimbursement is cumulative with and not exclusive of its subrogation right and it may choose to exercise either or both rights of recovery. The Plan will notify You or Your representative of its interest and maintain contact throughout the process.

You or Your representative agrees to cooperate with the Plan and do whatever is necessary to secure the Plan's rights of subrogation and reimbursement under this Contract. This includes notifying the Plan promptly and in writings when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries. You or Your representative will do nothing to prejudice the Plan's rights as set out above. This includes, but is not limited to, refraining from making settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the Plan. Failure to cooperate with the Plan as outlined herein will operate as an assignment to the Plan of the proceeds of any settlement, judgment or other payment received by You to the extent of the full cost of all benefits provided by the Plan.

[When Your Health Plan is governed by ERISA, the Plan's recovery rights will be a first priority claim even if the payment of such claim results in a recovery to You which is insufficient to compensate You in part or in whole for the damages they sustained. Also, if Your Health Plan is governed by ERISA, no court costs or attorney fees may be deducted from the Plan's recovery.

For Health Plans not governed by ERISA, the Plan's recovery rights will not be exercised until You are fully compensated for the damages You sustained. Additionally, for Health Plans not governed by ERISA, the Plan will reduce its recovery claim by a proportional share of court costs or attorney fees incurred by You in obtaining a recovery.]

SECTION 10
COORDINATION OF BENEFITS

10.1 This Coordination of Benefits provision applies when You are entitled to Covered Services under this Plan and one or more other health benefit Plans (as defined below). This method of coordination of benefits is sometimes referred to as the "Benefit less Benefit" or non-duplication of benefits method. Unless required by law to pay first, We will pay after Your other health benefit Plan and may reduce the benefits We pay according to the terms of this Plan.

10.2 For purposes of this Section 10, "health benefit Plan" means any of the following that provides benefits or services for medical or dental care or treatment:

> insurance, closed panel or other forms of individual, group or group-type payment (whether insured or uninsured); Hospital indemnity benefits in excess of $200 per day; medical care components of long-term care Contracts such as skilled nursing care; Medical Benefits under group or individual automobile Contracts; and Medicare, or other governmental benefits as permitted by law.

"Health benefit Plan" does not include: amounts of Hospital indemnity insurance of $200 or less per day; school accident type payment, benefits for non-medical components of group long-term care policies; Medicaid policies and payment under other governmental Plans, unless permitted by law.

10.3 When this Plan is secondary, benefits under the primary Plan shall be coordinated with benefits provided under this Plan in order to avoid duplicate payment. If the benefits under the primary Plan for which You are seeking payment are less than the benefits set forth in this Plan and this Plan is secondary, this Plan shall Cover the difference between such benefits under the primary Plan and the benefits set forth in this Plan. If the benefits under the primary Plan for which You are seeking payment are equal to or exceed the benefits set forth in this Plan and this Plan is secondary, this Plan shall not provide any additional payment or pay any additional amounts.

SECTION 11
GENERAL PROVISIONS

11.1 Applicability.

The provisions of this Contract shall apply equally to the Subscriber and Dependents. All benefits and privileges made available to You shall be available to Your Dependents.

11.2 Choice of Law.

This Contract will be administered under the laws of the State of Tennessee.

11.3 Discounts and Rebates.

As a Member of this Plan, You understand and agree that this Plan may receive a retrospective discount or rebate from a Participating Provider or vendor, related to the aggregate volume of services, supplies, equipment or pharmaceuticals purchased by Members enrolled in any Coventry Plan. Though Members shall not share in such retrospective volume-based discounts or rebates, such aggregated rebates will be considered in Our prospective Premium calculations.

11.4 Discretionary Authority.

We shall have the right, subject to Your rights under the Contract, to interpret the benefits of the Contract, applicable Riders, terms, conditions, limitations, and Exclusions set out in the Contract in making factual determinations related to the Contract, its benefits, and Members and in construing any disputed or ambiguous terms.

11.5 Entire Agreement.

This Contract shall constitute the entire agreement between the parties. This Contract is comprised of this Individual Member Contract, Schedule of Benefits and Covered Services, applicable Riders, and Amendments.

11.6 Exhaustion of Administrative Remedies.

You may not bring a cause of action hereunder in a court or other governmental tribunal, unless and until all administrative remedies set forth in this Contract have first been exhausted.

11.7 Misstatements.

Statements and descriptions in any application for an insurance policy during negotiations for such policy by or on behalf of the insured shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or Contract, unless they are fraudulent or material to the acceptance of the risk by the insurer, the hazard assumed by the insurer, or the insurer in good faith would either not have issued the policy or Contract in as large an amount or at the Premium rate as applied for or would not have provided Coverage with respect to the hazard resulting in the loss if the true facts had been known to the insurer as required either by the application for the policy or Contract or otherwise.

11.8 Nontransferable.

No person other than You is entitled to receive Coverage for health care services or other benefits to be furnished by Us under this Contract. Such right to Covered health care services or other benefits is not transferable.

11.9 Policies and Procedures.

We may adopt policies, procedures, rules, and interpretations to promote orderly and efficient administration of this Agreement.

11.10 Relationship Among Parties Affected by Contract.

The relationship between CHL and Participating Providers is that of independent Contractors. Participating Providers are not agents or employees of CHL nor is any employee of CHL an employee or agent of Participating Providers. Participating Providers shall maintain the Provider-patient relationship with You and are solely responsible to You for all Participating Provider services.

11.11 Reservations and Alternatives.

We reserve the right to Contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein.

11.12 Severability.

In the event that any provision of this Contract is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Contract, which shall continue in full force and effect in accordance with its remaining terms.

11.13 Valid Amendment.

No change in this Contract shall be valid, unless approved by an officer of CHL and evidenced by endorsement on this Contract and/or by amendment to this Contract and agreed to, in writing, by You, as required in accordance with regulations promulgated according to the State of Tennessee and federal guidelines. Such amendment will be incorporated into this Contract.

11.14 Waiver.

The failure of CHL or You to enforce any provision of this Contract shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Contract shall not be deemed or construed to be a waiver of such default.

SECTION 12
DEFINITIONS

Any capitalized terms listed in this section shall have the meaning set forth below whenever the capitalized term is used in this Contract.

12.1 Allowed Amount.

Maximum amount on which payment is based for Covered health care services. This may be called "eligible expense," "payment allowance," or "negotiated rate." If Your Provider charges more than the Allowed Amount, You may have to pay the difference.

12.2 Appeal.

A request for Your health insurer or Plan to review a decision or a Grievance again.

12.3 Authorization, Authorize or Prior Authorization.

CHL has given approval for payment for certain services to be performed and an Authorization number has been assigned. Upon Authorization, all inpatient Hospital stays are then subject to concurrent review criteria established by CHL. If You need specialty services from a Non-Participating Provider, an Authorization means the Member's PCP or OB-GYN Physician has recommended a Non-Participating Provider for treatment of a specific condition, and CHL has assigned an Authorization for a certain number of visits or days. Authorization does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

12.4 Coinsurance.

Your share of the costs of a Covered health care service, calculated as a percentage (for example, 20%) of the Allowed Amount for the service. You pay Coinsurance *plus* any Deductibles You owe. For example, if Our Allowed Amount for an office visit is $100 and You've met Your Deductible, Your Coinsurance payment of 20% would be $20. We pay the rest of the Allowed Amount.

12.5 Contract.

The Individual Member Contract, Schedule of Benefits, Covered Services, and Exclusions, and all applicable Riders, Amendments, and endorsements together form the Contract.

12.6 Convenience Care.

A condition that requires Convenience Care is an unexpected illness or injury that does not constitute an Emergency Medical Condition or an urgent situation but requires medical attention when You cannot see Your family doctor right away. Examples of Convenience Care conditions include minor sicknesses, rashes, ear aches, sore throats, stomach aches, and similar problems. Convenience Care Centers are also useful for flu shots, vaccinations, and other shots.

12.7 Copayment.

A fixed amount (for example, $15) You pay for a Covered health care service, usually when You receive the service. The amount can vary by the type of Covered health care service, device, supply and/or drug. If the Allowed Amount for the Covered Service or Covered Drug is less than Your Copayment, You will pay the Allowed Amount..

12.8 Cosmetic Services and Surgery.

Surgery or supplies to change the texture or appearance of the skin or the relative size or position of any part of the body when such surgery is performed primarily for psychological purposes and is

not needed to correct or substantially improve a bodily function or prevent or treat illness or disease unless mandated by law. Removal of skin lesions is considered Cosmetic unless the lesions interfere with normal body functions or malignancy is suspected.

12.9 Coventry Transplant Network Facility.

A Provider or Facility designated by Us to provide transplant services and treatment to Members.

12.10 Covered Drug

The Prescription Drugs and Specialty Drugs that are prescribed by a Prescribing Provider, included on Our current Formulary, approved by Us and not otherwise Excluded from Coverage in this Contract. A list of Covered Drugs can be found on Our website, along with criteria for their approval. Some Covered Drugs may not be Authorized for Coverage as a treatment for Your diagnosis.

12.11 Covered Services or Coverage.

The services and supplies provided to You for which CHL will make payment, as described in the Contract.

12.12 Customer Service and Customer Service Department.

Our Customer Service Department is available to answer any questions or concerns You may have about Your Coverage or Our policies or procedures, including, but not limited to, verification of benefits, Prior Authorization requirements, coordination of benefits information, and procedures for filing an Inquiry or Complaint. You may reach Our Customer Service Department at the telephone number on Your Member ID card.

12.13 Deductible.

The amount You owe for health care services before We begin to pay. For example, if Your Deductible is $1,000, Your Plan will not pay anything until You have met Your $1,000 Deductible for Covered Services subject to the Deductible. The Deductible may not apply to all services.

12.14 Dependent.

Any member of a Subscriber's family, who meets the eligibility requirements as outlined in this Contract.

12.15 Directory of Health Care Providers.

A paper or electronic listing of Participating Providers. Please be aware the information in the Directory is subject to change.

12.16 Durable Medical Equipment (DME).

Equipment and supplies ordered for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics. Please see Section 5 for the specifics of Your Coverage.

12.17 Emergency Medical Condition.

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

12.18 Emergency Room Care.

Emergency Services received in an Emergency room.

12.19 Emergency Services.

Evaluation of an Emergency Medical Condition and treatment to keep the condition from getting worse.

More specifically, Emergency Services means those health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his/her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

- Placing the Member's health in serious jeopardy;
- Placing the health of a pregnant Member and the health of her unborn child in serious jeopardy;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

If You received Emergency Care for services Covered under this Contact, and cannot reasonably reach a Participating Provider, You will pay the same amount to a Non-Participating Provider for the Emergency Covered Service that You would have paid to a Participating Provider.

12.20 Excluded Services.

Health care services that We do not pay for or provide Coverage for.

12.21 Experimental or Investigational.

A health product or service is deemed Experimental or Investigational <u>if one or more of the following conditions are met</u>:

- Any drug not approved for use by the FDA; any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature; or any drug that is classified as IND (Investigational new drug) by the FDA. As used herein, off-label prescribing means prescribing Prescription Drugs for treatments other than those stated in the labeling approved by the FDA;

- Any health product or service that is subject to the Investigational Review Board (IRB) review or approval;

- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, III, or IV as set forth by FDA regulations, subject to Section 6;

- Any health product or service whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed, Medical Literature.

12.22 Formulary.

A listing of specific generic and brand name Prescription Drugs which are approved by Us and will be dispensed to You through a Participating Pharmacy. This listing is subject to periodic review and modification by Us at Our discretion The Formulary is available for review on Our website, or by contacting Our Customer Service Department.

12.23 Free Standing Facility.

A Facility not affiliated with a Hospital.

12.24 Grievance.

A complaint that You communicate to Us.

12.25 Habilitative Services.

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

12.26 Health Insurance.

The Contract that requires that We pay some or all of Your health care costs for Covered Services in exchange for a Premium.

12.27 Health Insurance Marketplace.

Means the governmental agency or non-profit entity that the U.S. Department of Health and Human Services has recognized as the organization that shall serve as the Health Insurance Marketplace for the geographic area in which the Subscriber resides.

12.28 Health Plan.

Coventry Health and Life Insurance Company.

12.29 Home Health Care.

Health care services a person receives at home. Please see Section 5, Covered Services for the specifics of Your Coverage.

12.30 Hospice Services.

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

12.31 Hospital.

An institution, operated pursuant to law, which: (a) is primarily engaged in providing health services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; (b) has twenty-four (24) hour nursing services on duty or on call; and (c) is accredited as a Hospital by the Joint Commission or the American Osteopathic Hospital Association, or certified under Title XVIII of the Social Security Act (the Medicare program). A Facility that is primarily a place for rest, custodial care or care of the aged, a nursing home, convalescent home or similar institution is not a Hospital.

12.32 Hospitalization.

Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

12.33 Hospital Outpatient Care.

Care in a Hospital that usually doesn't require an overnight stay.

12.34 In-Network Coinsurance.

The percent (for example, 20%) You pay of the Allowed Amount for Covered Services to Providers who Contract with Us. In-Network Coinsurance usually costs You less than Out-of-Network Coinsurance.

12.35 In-Network Copayment.

A fixed amount (for example, $15) You pay for Covered health care services to Providers who Contract with Us. In-Network Copayments usually are less than Out-of-Network Copayments.

12.36 In-Network Provider, Participating Provider, or Preferred Provider.

A Provider who has entered into a direct or indirect Contract with Us to provide services to You at a discount. Check Your policy to see if You can see any Preferred Providers or if We have a tiered Network and You must pay extra to see some Providers.

12.37 Mail Order.

A [90-93]-day supply of an approved Maintenance Drug obtained through a Participating Mail Order Pharmacy.

12.38 Mail Order Pharmacy.

Where applicable, a Participating Pharmacy Contracted by Us to provide Maintenance Drugs through the mail.

12.39 Maintenance Drug(s).

Those Prescription Drugs which are prescribed for long-term or chronic conditions, such as high blood pressure or diabetes, not written for episodic treatments of medical conditions, and designated by Us as Maintenance Drugs. The list of Maintenance Drugs is available for review on Our website, or by contacting Our Customer Service Department .

12.40 Maximum Allowable Cost (MAC).

The price assigned to Prescription Drugs that will be Covered at the generic product level, subject to periodic review and modification by Us.

12.41 Medical Benefit.

Those Covered Services set forth in Section 5 that are not described or included in the Prescription Drugs Section of the Schedule.

12.42 Medical Director.

The Physician specified by Us as the Medical Director**.**

12.43 Medically Necessary / Medical Necessity.

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine**.**

Medically Necessary means those services, supplies, equipment, and facilities charges that are not expressly Excluded under this Contract and determined by Us to be:

- Medically appropriate, which means that the expected health benefits (such as increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks. The phrase "medically appropriate" embodies the concepts known as "the art of medicine," and "standard of care." It stands to reason that the expected health benefits (outcomes) must outweigh the risks for a service to be deemed Medically Necessary. The service should be demonstrably superior to alternatives, including no service at all;

- Services or supplies that are consistent with the diagnosis of Your medical condition;

- Necessary to meet Your basic health needs as a minimum requirement;

- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service, without compromising the quality of care;

- With respect to drugs, the drug is the most cost-efficient drug for treatment of the Member's condition without compromising the quality of care;

- Consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations, or governmental agencies that are generally accepted by the Plan;

- Required for reasons other than comfort or convenience of the Member or Member's family or convenience of Your Physician;

- Not Experimental or Investigational as determined by Us under Our Experimental or Investigational procedures determination policy;

- Necessary to meet Your basic health needs as a minimum requirement; and

- Of demonstrated value based on the clinical evidence reported by the Peer-Reviewed published medical literature, generally accepted standards of medical practice, the evidence-based guidelines from nationally recognized professional health care organizations and by generally recognized academic medical experts; that is, it is not Experimental or Investigational.

For purposes of this definition, "service" refers to health care services, procedures, equipment, devices and/or drugs.

12.44 Member.

Any Subscriber, Dependent, or Qualified Beneficiary, as that term is defined under COBRA, who enrolled for Coverage under this Contract in accordance with its terms and conditions.

12.45 Member Effective Date.

The date entered on Our records as the date when Coverage for a Member under this Contract begins in accordance with the terms of this Contract, which Coverage shall begin at 12:01 a.m. on such date.

12.46 Network.

The facilities, Providers and suppliers We have Contracted with to provide health care services.

12.47 Non-Formulary Drugs.

Prescription Drugs that are that are not included on Our Formulary at the time the Prescription Drug is dispensed to a Member. Non-Formulary Drugs may include either generic or brand-name Prescription Drugs.

12.48 Non-Participating Pharmacy.

Any registered, licensed pharmacy with whom Our pharmacy benefit administrator or We do not have a Contract.

12.49 Non-Preferred Pharmacy.

A Pharmacy that is a Participating Pharmacy, but is not a Preferred Pharmacy.

12.50 Non-Preferred Provider, Non-Participating Provider, or Out-of-Network Provider.

A Provider who doesn't have a Contract with the Us to provide services to You. You'll pay more to see a Non-Preferred Provider. Check Your policy to see if You can go to all Providers who have Contracted with Us, or if We have a tiered Network and You must pay extra to see some Providers.

12.51 Out-of-Network Coinsurance.

The percent (for example, 40%) You pay of the Allowed Amount for Covered Services to Providers who do *not* Contract with Us. Out-of-Network Coinsurance usually costs You more than In-Network Coinsurance.

12.52 Out-of-Network Copayment.

A fixed amount (for example, $30) You pay for Covered Services from Providers who do not Contract with Us. Out-of-Network Copayments usually are more than In-Network Copayments.

12.53 Out-of-Network Rate (ONR).

The Allowed Amount for Covered Services rendered by Non-Participating Providers for Out-of Network Covered Services. See Section 1.7 for more information on the Out-of-Network Rate.

12.54 Out-of-Pocket Maximum.

The limit on the total amount of Coinsurance, Copayments and Deductibles You must pay out of Your pocket annually for In-Network Covered Services.

12.55 Participating Pharmacy.

Any registered, licensed retail pharmacy with whom the pharmacy benefit administrator or We have a Contract with to dispense Prescription Drugs to Members.

12.56 Participating Provider

A Provider within the Carelink [Hospital Provider] Network] who has entered into a direct or indirect written agreement with the Plan to provide Health Services to Members. The participation status of Providers may change from time to time.

12.57 Patient Costs.

Any fee or expense for a Medically Necessary service incurred as a result of treatment provided to the Member for purposes of a clinical trial for the treatment of cancer. Patient Costs do not include the cost: (a) of any drug or device provided in a phase I or II cancer clinical trial; (b) of any Investigational drug or device; (c) of non-health services that might be required for a Member to receive treatment or intervention; (d) of managing the research of the clinical trial; and (e) that would not be Covered under the Plan**.**

12.58 Peer-Reviewed Medical Literature.

A phrase that is defined by two elements:

1. It refers to the requirement that medical literature on a topic is only considered relevant if it is a scientific study, which has been published in the English language (mostly American) only after review by academic experts for structure of study and validity of conclusions, prior to acceptance for publication; and

2. Based on a methodology used by certain authoritative bodies (including The National Cancer Institute PDQ Guidelines for Cancer Treatment and the International Consensus Conference on Bone Marrow Transplantation), the medical literature is graded for its quality using a 2-by-2 grid based on two parameters: **strength** of the evidence and **effectiveness**.

Strength of evidence is graded from the highest level of evidence to the lowest, as follows:

Level 1: Randomized, controlled trial

Level 2: Cohort/Case Control Study

Level 3: Systematic Literature Review

Level 4: Large consecutive case series

Level 5: Small consecutive case series

Level 6: Textbook chapters (opinion of a respected authority)

Level 7: Case report

Effectiveness is evaluated using 4 measurements:

1. Is the proposed treatment harmful or beneficial?
2. Do the results favor the study (Experimental) group or the control group?
3. Is the outcome considered statistically weak or strong?
4. Is the study design weak or strong?

12.59 Physician.

Any Doctor of Medicine (“M.D”) or Doctor of Osteopathy (“D.O.”), who is duly licensed and qualified under the law of the jurisdiction in which treatment is received.

12.60 Physician Services.

Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

12.61 PPACA

Patient Protection and Affordable Coverage Act of 2010, including any regulations promulgated thereunder.

12.62 Plan.

A benefit Plan that provides for Your health care services.

12.63 Preferred Pharmacy.

Those Participating Pharmacies that are identified as Preferred Pharmacies by Us. Please contact Our Customer Services Department for a list of Preferred Pharmacies.

12.64 Premium.

The amount that must be paid for Your Health Insurance or Plan. You usually pay it monthly, quarterly, or yearly.

12.65 Prescribing Provider.

Any person holding the degree of doctor of medicine, doctor of osteopathy, doctor of dental medicine or doctor of dental surgery or any other health care professional who is duly licensed in the state in which the Prescription Drug is prescribed to prescribe medications in the ordinary course of his or her professional practice.

12.66 Prescription Drug Coverage.

Health Insurance or Plan that helps pay for Prescription Drugs and medications.

12.67 Prescription Drugs.

A drug that:

- is provided for outpatient administration; and
- has been approved by the Food and Drug Administration for a specific use; and
- under federal or state law, can be dispensed only pursuant to a Prescription Order (legend drug); and
- has not been otherwise limited or Excluded under this Contract.

This definition includes some limited over-the-counter medications or disposable medical supplies (*e.g.*, insulin and diabetic supplies). It includes medications for treatment of certain types of cancer approved by the Federal Food and Drug Administration and proven effective and accepted for the treatment of a specific type of cancer in any one of the following established reference compendia:

- The American Medical Association Drug Evaluations;
- The American Hospital Formulary Service Drug Information; or
- The United States Pharmacopeia Drug Information.

A compound substance is considered a Prescription Drug if one or more of the items compounded is a Prescription Drug.

12.68 Prescription Order or Refill.

The Authorization for a Prescription Drug issued by a Prescribing Provider who is duly licensed to make such an Authorization in the ordinary course of his or her professional practice.

12.69 Primary Care Physician (PCP).

A Participating Provider who practices in the fields of Internal Medicine, Family Practice, General Practice, or Pediatrics who is designated as a Participating Provider by the Plan and who is responsible for providing care to Members or referring Members to other Providers in order to receive care. Note: Female members may also select a Woman's Principal Health Care Provider (WHPCP) in addition to their PCP. This physician specializes in women's health care needs and practices in the fields of Family Practice or Obstetrics and Gynecology.

12.70 Primary Care Provider.

A Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse Specialist or Physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services

12.71 Prior Authorization.

A decision by Us that a health care service, treatment plan, Prescription Drug or Durable Medical Equipment is Medically Necessary [or that any required referral was obtained from Your PCP]. Sometimes called Prior Authorization, prior approval, or precertification. We may require Prior Authorization for certain services before You receive them, except in an Emergency. Prior Authorization isn't a promise We will Cover the cost.

12.72 Provider or Provider Network.

A Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care Facility licensed, certified or accredited as required by state law**.**

12.73 Qualified Individual.

A Qualified Individual is an individual that the Health Insurance Marketplace has determined is eligible to enroll through the Health Insurance Marketplace in Our Plan, pursuant to the requirements of 45 C.F.R. §.155.305.

12.74 Reconstructive Surgery.

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

12.75 Rehabilitation Services.

Health care services that help a person keep get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric Rehabilitation Services in a variety of inpatient and/or outpatient settings.

12.76 Schedule of Benefits.

Your Schedule of Benefits lists the services available to You under the Contract, as well as the Deductibles, Coinsurance, and Copayments associated with each service. There are other factors that impact how Your Coverage works and those are included in this Contract in the Exclusions & Limitations.

12.77 Service Area.

The geographic area served by CHL as approved by the Department of Human Resources and the Department of Insurance and shown in Section 13, in which CHL's health services are available and readily accessible to enrollees. CHL's Service Area is subject to change, and may not include all counties in the State of Tennessee.

12.78 Specialist.

A Physician Specialist focuses on a specific area of medicine to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has more training in a specific area of health care.

12.79 Specialty Drugs.

Defined by Us. Typically high-cost drugs, including but not limited to oral, topical, inhaled, inserted or implanted and injected routes of administration. These are identified in the Formulary with "SP" next to the name of the drug. Included characteristics of Specialty Drugs are that they:

(i) are used to treat and diagnose rare or complex diseases;

(ii) require close clinical monitoring and management;

(iii) frequently require special handling; and

(iv) may have limited access or distribution.

Specialty Drugs also include self-administered injectables, which are Prescription Drugs that, as defined by Us, are commonly and customarily administered by the Member and are Covered only when dispensed by the Specialty Pharmacy or other Pharmacy designated by Us. Examples of self-administered injectables include, but are not limited to, the following: multiple sclerosis agents, growth hormones, colony stimulating factors given more than once monthly, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain injectable HIV drugs, certain osteoporosis agents and heparin products. Note: For definition purposes, other injectable drugs that are acquired through the retail Pharmacy, injectable diabetes agents (such as insulin and glucagons), bee sting kits, Imitrex and injectable contraceptives are not considered to be self-administered injectables.

12.80 Specialty Pharmacy.

A pharmacy that has a Contract with Us and is designated by Us as a Specialty Pharmacy who provides certain Covered Drugs, including, but not limited to, Prescription Drugs and Specialty Drugs Orders or Refills.

12.81 Subscriber.

The eligible individual that has elected CHL Coverage for himself/ herself and/or any eligible Dependents through submission of an enrollment application and for whom or on whose behalf Premiums have been received by Us.

12.82 Urgent Care.

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Room Care.

If a condition requiring Urgent Care develops, You may go to the nearest Urgent Care Center, Participating Physician's office, or any other Provider for treatment. This treatment may be subject

to a Copayment and/or Coinsurance. Examples of Urgent Care conditions include fractures, lacerations, or severe abdominal pain.

12.83 Value Formulary or Tier Zero Drugs.

Group of medications on the Formulary addendum, Value Formulary Tier Zero Drugs, that are available for a limited period of time at no Copayment to Members who meet the Plan criteria specified in the Formulary addendum.

12.84 We, Us, Our.

Coventry Health and Life Insurance Company

12.85 You / Your.

A Member Covered under this Contract.

SECTION 13
SERVICE AREA DESCRIPTION

The current Service Area consists of the following counties:

1. Fayette
2. Shelby
3. Tipton

COVENTRY
Health and Life Insurance Company

5350 Poplar Ave, Suite 390 Memphis, Tennessee 38119
1-855-449-2889
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This Schedule of Benefits, Covered Services, and Exclusions is part of your Individual Member Contract but does not replace it. Many words are defined elsewhere in the Contract, and other limitations or exclusions may be listed in other sections of your Contract. Reading this Schedule by itself could give you an inaccurate impression of the terms of your coverage. This Schedule must be read with the rest of your Contract. Prior authorization may be required for specific services.

BENEFIT CATEGORIES AND COST SHARING

Carelink from Coventry	***Gold $5 Copay PPO Baptist***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 - OON***
Annual Deductible (Ded.)	**Individual: $1,750**	**Individual: $6,400**
	Family: $3,500	**Family: $12,800**
Coinsurance (Coins.)	**20%**	**50%**
Out-of-Pocket Maximum	**Individual: $5,000**	**Individual: Unlimited**
	Family: $10,000	**Family: Unlimited**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**$5 Copay**	**Ded./Coins.**
Specialist	**First 5 Visits: $50 Copay; 6+ Visits: $50 Copay + Ded.**	**Ded./Coins.**
Surgery		
Primary Care Physician's Office	**Included in Office Visit**	**Ded./Coins.**
Specialist's Office	**Included in Office Visit**	**Ded./Coins.**
Free-Standing Facility	**$250 Copay + Ded.**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**Ded./Coins.**
Outpatient Facility and Physician Services	**Ded./Coins.**	**Ded./Coins.**
Home Health Care/Hospice ***Limited to 60 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Skilled Nursing Facility ***Limited to 60 days per year***	**Ded./Coins.**	**Ded./Coins.**
Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**Ded./Coins.**	**Ded./Coins.**
Cleft Lip and Palate	**Ded./Coins.**	**Ded./Coins.**
Chiropractic Care ***Limited to 20 visits per year***	**First 5 Visits: $50 Copay; 6+ Visits: $50 Copay + Ded.**	**Ded./Coins.**
EMERGENCY CARE		
Urgent Care	**$75 Copay**	**Ded/Coins.**

Emergency Room Care	**First 3 Visits: $250 Copay; 4+ Visits: $250 Copay + Ded.**	**First 3 Visits: $250 Copay; 4+ Visits: $250 Copay + Ded.**
Emergency Advanced Imaging / High Tech Radiology	**Ded./Coins.**	**Ded./20% Coins.**
Emergency Transportation/ Ambulance	**$500 Copay**	**$500 Copay**
HOSPITALIZATION		
Inpatient Services	**Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
Inpatient Physician and Surgical Services	**Ded./Coins.**	**Ded./Coins.**
TRANSPLANT		
Transplants	**Ded./Coins.**	**Not Covered**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visits	**$0**	**Ded./Coins.**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**One Time $250 Copay**	**Ded./Coins.**
Outpatient Ultrasound	**Ded./Coins.**	**Ded./Coins.**
All Inpatient Services/Facility Charges	**Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**First 5 Visits: $50 Copay, 6+ Visits: $50 Copay + Ded.**	**Ded./Coins.**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**Ded./Coins.**	**Ded./Coins.**
Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Habilitation Services ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**

Durable Medical Equipment	**Ded./Coins.**	**Ded./Coins.**
LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**Included in PCP Office Visit**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**Ded./Coins.**
Diagnostic Mammogram		
Primary Care Physician's Office	**Ded./Coins.**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Free-Standing Facility	**Ded./Coins.**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**Ded./Coins.**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**Ded./Coins.**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Free-Standing Facility	**$250 Copay**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**$250 Copay + Ded./Coins.**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**Ded./Coins.**
Preventive/Screening Mammogram		
Primary Care Physician's Office	**$0**	**Ded./Coins.**
Specialist's Office	**$0**	**Ded./Coins.**
Free-Standing Facility	**$0**	**Ded./Coins.**
Outpatient	**$0**	**Ded./Coins.**
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE		
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**	
Vision Screening for Children	**One routine eye examination per year**	
Eye Glasses for Children[i]	**One pair of standard eyeglass lenses or contact lenses per year; one frame every year**	
PRESCRIPTION DRUGS		
Pharmacy	**Separate $250 Rx Deductible**	
Tier 1A: Lower Cost Preferred Generic Drugs	**Preferred Pharmacy $3 / Non Preferred Pharmacy $10 / Mail Order $6**	
Tier 1: Preferred Generic Drugs	**Preferred Pharmacy $5 / Non Preferred Pharmacy $10 / Mail Order $10**	
Tier 2: Preferred Brand Drugs	**Preferred Pharmacy $30 + Deductible / Non Preferred Pharmacy $40 + Deductible / Mail Order $75 + Deductible**	

Tier 3: Non-Preferred Brand/Generic Drugs	**Preferred Pharmacy $60 + Deductible / Non Preferred Pharmacy $75 + Deductible / Mail Order $180 + Deductible**
Tier 4: Preferred Specialty Drugs	**Preferred Pharmacy Deductible + 20% Coinsurance**
Tier 5: Non-Preferred Specialty Drugs	**Preferred Pharmacy Deductible + 30% Coinsurance**

[i] Members receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

COVENTRY
Health and Life Insurance Company

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This benefit Plan is only available for an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, with a household income less than three hundred percent (300%) of the Federal Poverty Level (FPL) and who is determined eligible to enroll in the Plan by the Health Insurance Marketplace.

BENEFIT CATEGORIES AND COST SHARING

Carelink from Coventry	***Gold $0 Copay PPO Baptist Indian No Cost Share***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 - OON***
Annual Deductible (Ded.)	**Individual: $0**	**Individual: $0**
	Family: $0	**Family: $0**
Coinsurance (Coins.)	**0%**	**0%**
Out-of-Pocket Maximum	**Individual: $0**	**Individual: $0**
	Family: $0	**Family: $0**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**$0**	**$0**
Specialist	**$0**	**$0**
Surgery		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**
Outpatient Facility and Physician Services	**$0**	**$0**
Home Health Care/Hospice ***Limited to 60 visits per year***	**$0**	**$0**
Skilled Nursing Facility ***Limited to 60 days per year***	**$0**	**$0**
Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**$0**	**$0**

Cleft Lip and Palate	**$0**	**$0**
Chiropractic Care ***Limited to 20 visits per year***	**$0**	**$0**
EMERGENCY CARE		
Urgent Care	**$0**	**$0**
Emergency Room Care	**$0**	**$0**
Emergency Advanced Imaging / High Tech Radiology	**$0**	**$0**
Emergency Transportation/ Ambulance	**$0**	**$0**
HOSPITALIZATION		
Inpatient Services	**$0**	**$0**
Inpatient Physician and Surgical Services	**$0**	**$0**
TRANSPLANT		
Transplants	**$0**	**$0**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visits	**$0**	**$0**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**$0**	**$0**
Outpatient Ultrasound	**$0**	**$0**
All Inpatient Services/Facility Charges	**$0**	**$0**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**$0**	**$0**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**$0**	**$0**
Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**$0**	**$0**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		

Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**$0**	**$0**
Habilitation Services ***Limited to 20 visits per year***	**$0**	**$0**
Durable Medical Equipment	**$0**	**$0**
Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**$0**	**$0**
Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**$0**	**$0**
LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Outpatient	**$0**	**$0**
Diagnostic Mammogram		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**$0**
Preventive/Screening Mammogram		**$0**
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**

PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE	
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**
Vision Screening for Children	**$0**
Eye Glasses for Children[i]	**$0**
PRESCRIPTION DRUGS	
Pharmacy	**$0**
Tier 1A: Lower Cost Preferred Generic Drugs	**$0**
Tier 1: Preferred Generic Drugs	**$0**
Tier 2: Preferred Brand Drugs	**$0**
Tier 3: Non-Preferred Brand/Generic Drugs	**$0**
Tier 4: Preferred Specialty Drugs	**$0**
Tier 5: Non-Preferred Specialty Drugs	**$0**

[i] Members receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

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This benefit Plan is only available for an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, who is determined eligible to enroll in the Plan by the Health Insurance, and therefore is not required to pay any cost sharing on any item or service that qualifies as an essential health benefit in the Health Insurance Marketplace market if that essential health benefit is furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603).

BENEFIT CATEGORIES AND COST SHARING

Carelink from Coventry	***Gold $5 Copay PPO Baptist Indian Provider No Cost Share***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 - OON***
Annual Deductible (Ded.)	**Individual: $1,750**	**Individual: $6,400**
	Family: $3,500	**Family: $12,800**
Coinsurance (Coins.)	**20%**	**50%**
Out-of-Pocket Maximum	**Individual: $5,000**	**Individual: Unlimited**
	Family: $10,000	**Family: Unlimited**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**$5 Copay**	**Ded./Coins.**
Specialist	**First 5 Visits: $50 Copay; 6+ Visits: $50 Copay + Ded.**	**Ded./Coins.**
Surgery		
Primary Care Physician's Office	**Included in Office Visit**	**Ded./Coins.**
Specialist's Office	**Included in Office Visit**	**Ded./Coins.**
Free-Standing Facility	**$250 Copay + Ded.**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**Ded./Coins.**
Outpatient Facility and Physician Services	**Ded./Coins.**	**Ded./Coins.**
Home Health Care/Hospice ***Limited to 60 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Skilled Nursing Facility ***Limited to 60 days per year***	**Ded./Coins.**	**Ded./Coins.**
Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**Ded./Coins.**	**Ded./Coins.**
Cleft Lip and Palate	**Ded./Coins.**	**Ded./Coins.**

Chiropractic Care ***Limited to 20 visits per year***	**First 5 Visits: $50 Copay; 6+ Visits: $50 Copay + Ded.**	**Ded./Coins.**
EMERGENCY CARE		
Urgent Care	**$75 Copay**	**Ded/Coins.**
Emergency Room Care	**First 3 Visits: $250 Copay; 4+ Visits: $250 Copay + Ded.**	**First 3 Visits: $250 Copay; 4+ Visits: $250 Copay + Ded.**
Emergency Advanced Imaging / High Tech Radiology	**Ded./Coins.**	**Ded./20% Coins.**
Emergency Transportation/ Ambulance	**$500 Copay**	**$500 Copay**
HOSPITALIZATION		
Inpatient Services	**Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
Inpatient Physician and Surgical Services	**Ded./Coins.**	**Ded./Coins.**
TRANSPLANT		
Transplants	**Ded./Coins.**	**Not Covered**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visits	**$0**	**Ded./Coins.**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**One Time $250 Copay**	**Ded./Coins.**
Outpatient Ultrasound	**Ded./Coins.**	**Ded./Coins.**
All Inpatient Services/Facility Charges	**Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**First 5 Visits: $50 Copay, 6+ Visits: $50 Copay + Ded.**	**Ded./Coins.**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**Ded./Coins.**	**Ded./Coins.**
Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**Ded./Coins.**	**$1,000 Admit + Ded./Coins.**

REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Habilitation Services ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Durable Medical Equipment	**Ded./Coins.**	**Ded./Coins.**
LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**Included in PCP Office Visit**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**Ded./Coins.**
Diagnostic Mammogram		
Primary Care Physician's Office	**Ded./Coins.**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Free-Standing Facility	**Ded./Coins.**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**Ded./Coins.**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**Ded./Coins.**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Free-Standing Facility	**$250 Copay**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**$250 Copay + Ded./Coins.**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**Ded./Coins.**
Preventive/Screening Mammogram		
Primary Care Physician's Office	**$0**	**Ded./Coins.**
Specialist's Office	**$0**	**Ded./Coins.**
Free-Standing Facility	**$0**	**Ded./Coins.**
Outpatient	**$0**	**Ded./Coins.**
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE		
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**	
Vision Screening for Children	**One routine eye examination per year**	

Eye Glasses for Children[i]	**One pair of standard eyeglass lenses or contact lenses per year; one frame every year**
PRESCRIPTION DRUGS	
Pharmacy	**Separate $250 Rx Deductible**
Tier 1A: Lower Cost Preferred Generic Drugs	**Preferred Pharmacy $3 / Non Preferred Pharmacy $10 / Mail Order $6**
Tier 1: Preferred Generic Drugs	**Preferred Pharmacy $5 / Non Preferred Pharmacy $10 / Mail Order $10**
Tier 2: Preferred Brand Drugs	**Preferred Pharmacy $30 + Deductible / Non Preferred Pharmacy $40 + Deductible / Mail Order $75 + Deductible**
Tier 3: Non-Preferred Brand/Generic Drugs	**Preferred Pharmacy $60 + Deductible / Non Preferred Pharmacy $75 + Deductible / Mail Order $180 + Deductible**
Tier 4: Preferred Specialty Drugs	**Preferred Pharmacy Deductible + 20% Coinsurance**
Tier 5: Non-Preferred Specialty Drugs	**Preferred Pharmacy Deductible + 30% Coinsurance**

[i] Members receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

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BENEFIT CATEGORIES AND COST SHARING

Carelink from Coventry	***Silver $10 Copay PPO Baptist***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 – Out of Network***
Annual Deductible (Ded.)	**Individual: $3,750**	**Individual: $6,400**
	Family: $7,500	**Family: $12,800**
Coinsurance (Coins.)	**30%**	**50%**
Out-of-Pocket Maximum	**Individual: $6,400**	**Individual: Unlimited**
	Family: $12,800	**Family: Unlimited**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**$10 Copay**	**Ded./Coins.**
Specialist	**First Visit: $75 Copay; 2+ Visits: $75 Copay + Ded.**	**Ded./Coins.**
Surgery		
Primary Care Physician's Office	**Included in PCP Office Visit**	**$250 Copay + Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**$250 Copay + Ded./Coins.**
Free-Standing Facility	**$250 Copay + Ded.**	**Ded./Coins.**
Outpatient	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
Outpatient Facility and Physician Services	**Ded./Coins.**	**Ded./Coins.**
Home Health Care/Hospice ***Limited to 60 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Skilled Nursing Facility ***Limited to 60 days per year***	**Ded./Coins.**	**Ded./Coins.**
Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**Ded./Coins.**	**Ded./Coins.**
Cleft Lip and Palate	**Ded./Coins.**	**Ded./Coins.**
Chiropractic Care ***Limited to 20 visits per year***	**First Visit: $75 Copay; 2+ Visits: $75 Copay + Ded.**	**Ded./Coins.**
EMERGENCY CARE		

Urgent Care	**$75 Copay**	**Ded./Coins.**
Emergency Room Care	**First Visit: $500 Copay; 2+ Visits: $500 Copay + Ded.**	**First Visit: $500 Copay; 2+ Visits: $500 Copay + Ded.**
Emergency Advanced Imaging / High Tech Radiology	**Ded./Coins.**	**Ded./30% Coins.**
Emergency Transportation/ Ambulance	**Ded./Coins.**	**Ded./Coins.**
HOSPITALIZATION		
Inpatient Services	**$500 Admit + Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
Inpatient Physician and Surgical Services	**Ded./Coins.**	**Ded./Coins.**
TRANSPLANT		
Transplants	**Ded./Coins.**	**Not Covered**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visit	**$0**	**Ded./Coins.**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**One Time $250 Copay**	**Ded./Coins.**
Outpatient Ultrasound	**Ded./Coins.**	**Ded./Coins.**
All Inpatient Services/Facility Charges	**$500 Admit + Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**First Visit: $75 Copay; 2+ Visits: $75 Copay + Ded.**	**Ded./Coins.**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**Ded./Coins.**	**Ded./Coins.**
Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**$500 Admit + Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**

Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Habilitation Services ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Durable Medical Equipment	**Ded./Coins.**	**Ded./Coins.**
LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**Included in PCP Office Visit**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**Ded./Coins.**
Diagnostic Mammogram		
Primary Care Physician's Office	**Ded./Coins.**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Free-Standing Facility	**Ded./Coins.**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**Ded./Coins.**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
Specialist's Office	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
Free-Standing Facility	**$250 Copay + Ded.**	**Ded./Coins.**
Outpatient	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**Ded./Coins.**
Preventive/Screening Mammogram		
Primary Care Physician's Office	**$0**	**Ded./Coins.**
Specialist's Office	**$0**	**Ded./Coins.**
Free-Standing Facility	**$0**	**Ded./Coins.**
Outpatient	**$0**	**Ded./Coins.**
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE		
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**	
Vision Screening for Children	**One routine eye examination per year**	
Eye Glasses for Children[i]	**One pair of standard eyeglass lenses or contact lenses per year; one frame every year**	
PRESCRIPTION DRUGS		
Pharmacy	**Separate $1,000 Rx Deductible**	
Tier 1A: Lower Cost Preferred Generic Drugs	**Preferred Pharmacy $5 / Non Preferred Pharmacy $20 / Mail Order $10**	

Tier 1: Preferred Generic Drugs	**Preferred Pharmacy $15 / Non Preferred Pharmacy $20 / Mail Order $30**
Tier 2: Preferred Brand Drugs	**Preferred Pharmacy $45 + Deductible / Non Preferred Pharmacy $55 + Deductible / Mail Order $112.50 + Deductible**
Tier 3: Non-Preferred Brand/Generic Drugs	**Preferred Pharmacy $75 + Deductible / Non Preferred Pharmacy $85 + Deductible / Mail Order $225 + Deductible**
Tier 4: Preferred Specialty Drugs	**Preferred Pharmacy Deductible + 30% Coinsurance**
Tier 5: Non-Preferred Specialty Drugs	**Preferred Pharmacy Deductible + 40% Coinsurance**

[i] Members receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

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This benefit Plan is only available for an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, with a household income less than three hundred percent (300%) of the Federal Poverty Level (FPL) and who is determined eligible to enroll in the Plan by the Health Insurance Marketplace.

BENEFIT CATEGORIES AND COST SHARING

Carelink from Coventry	***Silver Basic $0 Copay PPO Baptist Indian No Cost Share***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 - OON***
Annual Deductible (Ded.)	**Individual: $0**	**Individual: $0**
	Family: $0	**Family: $0**
Coinsurance (Coins.)	**0%**	**0%**
Out-of-Pocket Maximum	**Individual: $0**	**Individual: $0**
	Family: $0	**Family: $0**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**$0**	**$0**
Specialist	**$0**	**$0**
Surgery		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**
Outpatient Facility and Physician Services	**$0**	**$0**
Home Health Care/Hospice ***Limited to 60 visits per year***	**$0**	**$0**
Skilled Nursing Facility ***Limited to 60 days per year***	**$0**	**$0**
Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**$0**	**$0**

Cleft Lip and Palate	**$0**	**$0**
Chiropractic Care ***Limited to 20 visits per year***	**$0**	**$0**
EMERGENCY CARE		
Urgent Care	**$0**	**$0**
Emergency Room Care	**$0**	**$0**
Emergency Advanced Imaging / High Tech Radiology	**$0**	**$0**
Emergency Transportation/ Ambulance	**$0**	**$0**
HOSPITALIZATION		
Inpatient Services	**$0**	**$0**
Inpatient Physician and Surgical Services	**$0**	**$0**
TRANSPLANT		
Transplants	**$0**	**$0**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visits	**$0**	**$0**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**$0**	**$0**
Outpatient Ultrasound	**$0**	**$0**
All Inpatient Services/Facility Charges	**$0**	**$0**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**$0**	**$0**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**$0**	**$0**
Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**$0**	**$0**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		

Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**$0**	**$0**
Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**$0**	**$0**
Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**$0**	**$0**
Habilitation Services ***Limited to 20 visits per year***	**$0**	**$0**
Durable Medical Equipment	**$0**	**$0**
LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Outpatient	**$0**	**$0**
Diagnostic Mammogram		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**$0**
Preventive/Screening Mammogram		**$0**
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**

PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE	
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**
Vision Screening for Children	**$0**
Eye Glasses for Children[i]	**$0**
PRESCRIPTION DRUGS	
Pharmacy	**$0**
Tier 1A: Lower Cost Preferred Generic Drugs	**$0**
Tier 1: Preferred Generic Drugs	**$0**
Tier 2: Preferred Brand Drugs	**$0**
Tier 3: Non-Preferred Brand/Generic Drugs	**$0**
Tier 4: Preferred Specialty Drugs	**$0**
Tier 5: Non-Preferred Specialty Drugs	**$0**

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BENEFIT CATEGORIES AND COST SHARING

Carelink from Coventry	***Silver $10 Copay PPO Baptist Indian Provider No Cost Share***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 – Out of Network***
Annual Deductible (Ded.)	**Individual: $3,750**	**Individual: $6,400**
	Family: $7,500	**Family: $12,800**
Coinsurance (Coins.)	**30%**	**50%**
Out-of-Pocket Maximum	**Individual: $6,400**	**Individual: Unlimited**
	Family: $12,800	**Family: Unlimited**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**$10 Copay**	**Ded./Coins.**
Specialist	**First Visit: $75 Copay; 2+ Visits: $75 Copay + Ded.**	**Ded./Coins.**
Surgery		
Primary Care Physician's Office	**Included in PCP Office Visit**	**$250 Copay + Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**$250 Copay + Ded./Coins.**
Free-Standing Facility	**$250 Copay + Ded.**	**Ded./Coins.**
Outpatient	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
Outpatient Facility and Physician Services	**Ded./Coins.**	**Ded./Coins.**
Home Health Care/Hospice ***Limited to 60 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Skilled Nursing Facility ***Limited to 60 days per year***	**Ded./Coins.**	**Ded./Coins.**

Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**Ded./Coins.**	**Ded./Coins.**
Cleft Lip and Palate	**Ded./Coins.**	**Ded./Coins.**
Chiropractic Care ***Limited to 20 visits per year***	**First Visit: $75 Copay; 2+ Visits: $75 Copay + Ded.**	**Ded./Coins.**
EMERGENCY CARE		
Urgent Care	**$75 Copay**	**Ded./Coins.**
Emergency Room Care	**First Visit: $500 Copay; 2+ Visits: $500 Copay + Ded.**	**First Visit: $500 Copay; 2+ Visits: $500 Copay + Ded.**
Emergency Advanced Imaging / High Tech Radiology	**Ded./Coins.**	**Ded./30% Coins.**
Emergency Transportation/ Ambulance	**Ded./Coins.**	**Ded./Coins.**
HOSPITALIZATION		
Inpatient Services	**$500 Admit + Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
Inpatient Physician and Surgical Services	**Ded./Coins.**	**Ded./Coins.**
TRANSPLANT		
Transplants	**Ded./Coins.**	**Not Covered**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visit	**$0**	**Ded./Coins.**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**One Time $250 Copay**	**Ded./Coins.**
Outpatient Ultrasound	**Ded./Coins.**	**Ded./Coins.**
All Inpatient Services/Facility Charges	**$500 Admit + Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**First Visit: $75 Copay; 2+ Visits: $75 Copay + Ded.**	**Ded./Coins.**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**Ded./Coins.**	**Ded./Coins.**

Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**$500 Admit + Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Habilitation Services ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Durable Medical Equipment	**Ded./Coins.**	**Ded./Coins.**
LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**Included in PCP Office Visit**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**Ded./Coins.**
Diagnostic Mammogram		
Primary Care Physician's Office	**Ded./Coins.**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Free-Standing Facility	**Ded./Coins.**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**Ded./Coins.**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
Specialist's Office	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
Free-Standing Facility	**$250 Copay + Ded.**	**Ded./Coins.**
Outpatient	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**Ded./Coins.**
Preventive/Screening Mammogram		
Primary Care Physician's Office	**$0**	**Ded./Coins.**
Specialist's Office	**$0**	**Ded./Coins.**
Free-Standing Facility	**$0**	**Ded./Coins.**
Outpatient	**$0**	**Ded./Coins.**
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE		
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**	

Vision Screening for Children	**One routine eye examination per year**
Eye Glasses for Children[i]	**One pair of standard eyeglass lenses or contact lenses per year; one frame every year**
PRESCRIPTION DRUGS	
Pharmacy	**Separate $1,000 Rx Deductible**
Tier 1A: Lower Cost Preferred Generic Drugs	**Preferred Pharmacy $5 / Non Preferred Pharmacy $20 / Mail Order $10**
Tier 1: Preferred Generic Drugs	**Preferred Pharmacy $15 / Non Preferred Pharmacy $20 / Mail Order $30**
Tier 2: Preferred Brand Drugs	**Preferred Pharmacy $45 + Deductible / Non Preferred Pharmacy $55 + Deductible / Mail Order $112.50 + Deductible**
Tier 3: Non-Preferred Brand/Generic Drugs	**Preferred Pharmacy $75 + Deductible / Non Preferred Pharmacy $85 + Deductible / Mail Order $225 + Deductible**
Tier 4: Preferred Specialty Drugs	**Preferred Pharmacy Deductible + 30% Coinsurance**
Tier 5: Non-Preferred Specialty Drugs	**Preferred Pharmacy Deductible + 40% Coinsurance**

[i] Members receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

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BENEFIT CATEGORIES AND COST SHARING

Carelink from Coventry	***Silver #1 $0 Copay PPO Baptist***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 – Out of Network***
Annual Deductible (Ded.)	**Individual: $0**	**Individual: $6,400**
	Family: $0	**Family: $12,800**
Coinsurance (Coins.)	**10%**	**50%**
Out-of-Pocket Maximum	**Individual: $1,500**	**Individual: Unlimited**
	Family: $3,000	**Family: Unlimited**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**$0**	**Ded./Coins.**
Specialist	**$25 Copay**	**Ded./Coins.**
Surgery		
Primary Care Physician's Office	**Coins.**	**$250 Copay + Ded./Coins.**
Specialist's Office	**Coins.**	**$250 Copay + Ded./Coins.**
Free-Standing Facility	**$100 Copay**	**Ded./Coins.**
Outpatient	**Coins.**	**$250 Copay + Ded./Coins.**
Outpatient Facility and Physician Services	**Coins.**	**Ded./Coins.**
Home Health Care/Hospice ***Limited to 60 visits per year***	**Coins.**	**Ded./Coins.**
Skilled Nursing Facility ***Limited to 60 days per year***	**Coins.**	**Ded./Coins.**
Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**Coins.**	**Ded./Coins.**
Cleft Lip and Palate	**Coins.**	**Ded./Coins.**
Chiropractic Care ***Limited to 20 visits per year***	**$25 Copay**	**Ded./Coins.**
EMERGENCY CARE		
Urgent Care	**$75 Copay**	**Ded./Coins.**
Emergency Room Care	**$100 Copay**	**$100 Copay**

Emergency Advanced Imaging / High Tech Radiology	**Coins.**	**Ded./10% Coins.**
Emergency Transportation/ Ambulance	**Coins.**	**Ded./Coins.**
HOSPITALIZATION		
Inpatient Services	**Coins.**	**$1,000 Admit + Ded./Coins.**
Inpatient Physician and Surgical Services	**Coins.**	**Ded./Coins.**
TRANSPLANT		
Transplants	**Coins.**	**Not Covered**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visits	**$0**	**Ded./Coins.**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**One Time $250 Copay**	**Ded./Coins.**
Outpatient Ultrasound	**Coins.**	**Ded./Coins.**
All Inpatient Services/Facility Charges	**Coins.**	**$1,000 Admit + Ded./Coins.**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**$25**	**Ded./Coins.**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**Coins.**	**Ded./Coins**
Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**Coins.**	**$1,000 Admit + Ded./Coins.**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**Coins.**	**Ded./Coins.**
Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**Coins.**	**Ded./Coins.**
Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**Coins.**	**Ded./Coins.**
Habilitation Services ***Limited to 20 visits per year***	**Coins.**	**Ded./Coins.**
Durable Medical Equipment	**Coins.**	**Ded./Coins.**

LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**Included in PCP Office Visit**	**Ded./Coins.**
Specialist's Office	**Included in the Specialist's Office Visit**	**Ded./Coins.**
Outpatient	**$5**	**Ded./Coins.**
Diagnostic Mammogram		
Primary Care Physician's Office	**Coins.**	**Ded./Coins.**
Specialist's Office	**Coins.**	**Ded./Coins.**
Free-Standing Facility	**Coins.**	**Ded./Coins.**
Outpatient	**Coins.**	**Ded./Coins.**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**Coins.**	**$250 Copay + Ded./Coins.**
Specialist's Office	**Coins.**	**$250 Copay + Ded./Coins.**
Free-Standing Facility	**$100 Copay**	**Ded./Coins.**
Outpatient	**Coins.**	**$250 Copay + Ded./Coins.**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**Ded./Coins.**
Preventive/Screening Mammogram		
Primary Care Physician's Office	**$0**	**Ded./Coins.**
Specialist's Office	**$0**	**Ded./Coins.**
Free-Standing Facility	**$0**	**Ded./Coins.**
Outpatient	**$0**	**Ded./Coins.**
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE		
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**	
Vision Screening for Children	**One routine eye examination per year**	
Eye Glasses for Children[I]	**One pair of standard eyeglass lenses or contact lenses per year; one frame every year**	
PRESCRIPTION DRUGS		
Pharmacy	**$0 Rx Deductible**	
Tier 1A: Lower Cost Preferred Generic Drugs	**Preferred Pharmacy $3 / Non Preferred Pharmacy $10 / Mail Order $6**	
Tier 1: Preferred Generic Drugs	**Preferred Pharmacy $5 / Non Preferred Pharmacy $10 / Mail Order $10**	

Tier 2: Preferred Brand Drugs	**Preferred Pharmacy $30 / Non Preferred Pharmacy $40 / Mail Order $75**
Tier 3: Non-Preferred Brand/Generic Drugs	**Preferred Pharmacy $55 / Non Preferred Pharmacy $65 / Mail Order $165**
Tier 4: Preferred Specialty Drugs	**Preferred Pharmacy 20% Coinsurance**
Tier 5: Non-Preferred Specialty Drugs	**Preferred Pharmacy 30% Coinsurance**

[i] Members receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

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BENEFIT CATEGORIES AND COST SHARING

Carelink from Coventry	***Silver #2 $10 Copay PPO Baptist***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 – Out of Network***
Annual Deductible (Ded.)	**Individual: $1,750**	**Individual: $6,400**
	Family: $3,500	**Family: $12,800**
Coinsurance (Coins.)	**30%**	**50%**
Out-of-Pocket Maximum	**Individual: $2,250**	**Individual: Unlimited**
	Family: $4,500	**Family: Unlimited**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**$10 Copay**	**Ded./Coins.**
Specialist	**$50 Copay**	**Ded./Coins.**
Surgery		
Primary Care Physician's Office	**Ded.**	**$250 Copay + Ded./Coins.**
Specialist's Office	**Ded.**	**$250 Copay + Ded./Coins.**
Free-Standing Facility	**Ded.**	**Ded./Coins.**
Outpatient	**$100 Copay + Ded.**	**$250 Copay + Ded./Coins.**
Outpatient Facility and Physician Services	**Ded.**	**Ded./Coins.**
Home Health Care/Hospice ***Limited to 60 visits per year***	**Ded.**	**Ded./Coins.**
Skilled Nursing Facility ***Limited to 60 days per year***	**Ded.**	**Ded./Coins.**
Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**Ded.**	**Ded./Coins.**
Cleft Lip and Palate	**Ded.**	**Ded./Coins.**
Chiropractic Care ***Limited to 20 visits per year***	**$50 Copay**	**Ded./Coins.**
EMERGENCY CARE		
Urgent Care	**$75 Copay**	**Ded./Coins.**

Emergency Room Care	**First Visit: $100 Copay; 2+ Visits: $100 Copay + Ded.**	**First Visit: $100 Copay; 2+ Visits: $100 Copay + Ded.**
Emergency Advanced Imaging / High Tech Radiology	**Ded.**	**Ded.**
Emergency Transportation/ Ambulance	**Ded.**	**Ded./Coins.**
HOSPITALIZATION		
Inpatient Services	**Ded.**	**$1,000 Admit + Ded./Coins.**
Inpatient Physician and Surgical Services	**Ded.**	**Ded./Coins.**
TRANSPLANT		
Transplants	**Ded.**	**Not Covered**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visits	**$0**	**Ded./Coins.**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**One Time $250 Copay**	**Ded./Coins.**
Outpatient Ultrasound	**Ded.**	**Ded./Coins.**
All Inpatient Services/Facility Charges	**Ded.**	**Ded.**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**$50 Copay**	**Ded./Coins.**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**Ded.**	**Ded./Coins.**
Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**Ded.**	**$1,000 Admit + Ded./Coins.**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**Ded.**	**Ded./Coins.**
Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**Ded.**	**Ded./Coins.**
Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**Ded.**	**Ded./Coins.**
Habilitation Services ***Limited to 20 visits per year***	**Ded.**	**Ded./Coins.**

Durable Medical Equipment	**Ded.**	**Ded./Coins.**
LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**Included in PCP Office Visit**	**Ded./Coins.**
Specialist's Office	**Included in Specialist Office Visit**	**Ded./Coins.**
Outpatient	**Ded.**	**Ded./Coins.**
Diagnostic Mammogram		
Primary Care Physician's Office	**Ded.**	**Ded./Coins.**
Specialist's Office	**Ded.**	**Ded./Coins.**
Free-Standing Facility	**Ded.**	**Ded./Coins.**
Outpatient	**Ded.**	**Ded./Coins.**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**$100 Copay + Ded.**	**$250 Copay + Ded./Coins.**
Specialist's Office	**$100 Copay + Ded.**	**/$250 Copay + Ded./Coins.**
Free-Standing Facility	**Ded.**	**Ded./Coins.**
Outpatient	**$100 Copay + Ded.**	**$250 Copay + Ded./Coins.**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**Ded./Coins.**
Preventive/Screening Mammogram		
Primary Care Physician's Office	**$0**	**Ded./Coins.**
Specialist's Office	**$0**	**Ded./Coins.**
Free-Standing Facility	**$0**	**Ded./Coins.**
Outpatient	**$0**	**Ded./Coins.**
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE		
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**	
Vision Screening for Children	**One routine eye examination per year**	
Eye Glasses for Children[i]	**One pair of standard eyeglass lenses or contact lenses per year; one frame every year**	
PRESCRIPTION DRUGS		
Pharmacy	**No Rx Deductible**	
Tier 1A: Lower Cost Preferred Generic Drugs	**Preferred Pharmacy $5 / Non Preferred Pharmacy $15 / Mail Order $10**	
Tier 1: Preferred Generic Drugs	**Preferred Pharmacy $10 / Non Preferred Pharmacy $15 / Mail Order $20**	
Tier 2: Preferred Brand Drugs	**Preferred Pharmacy $35 / Non Preferred Pharmacy $45 / Mail Order $87.50**	

Tier 3: Non-Preferred Brand/Generic Drugs	**Preferred Pharmacy $75 / Non Preferred Pharmacy $85 / Mail Order $225**
Tier 4: Preferred Specialty Drugs	**Preferred Pharmacy 30% Coinsurance**
Tier 5: Non-Preferred Specialty Drugs	**Preferred Pharmacy 40% Coinsurance**

[i] Members receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

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BENEFIT CATEGORIES AND COST SHARING

Carelink from CoventryOne	***Silver #3 $10 Copay PPO Baptist***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 – Out of Network***
Annual Deductible (Ded.)	**Individual: $3,750**	**Individual: $6,400**
	Family: $7,500	**Family: $12,800**
Coinsurance (Coins.)	**30%**	**50%**
Out-of-Pocket Maximum	**Individual: $5,200**	**Individual: Unlimited**
	Family: $10,400	**Family: Unlimited**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**$10 Copay**	**Ded./Coins.**
Specialist	**First Visit $75 Copay; 2+ Visits: $75 Copay + Ded.**	**Ded./Coins.**
Surgery		
Primary Care Physician's Office	**Ded./Coins.**	**$250 Copay + Ded./Coins.**
Specialist's Office	**Ded./Coins**	**$250 Copay + Ded./Coins.**
Free-Standing Facility	**$250 Copay + Ded.**	**Ded./Coins.**
Outpatient	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
Outpatient Facility and Physician Services	**Ded./Coins**	**Ded./Coins.**
Home Health Care/Hospice ***Limited to 60 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Skilled Nursing Facility ***Limited to 60 days per year***	**Ded./Coins.**	**Ded./Coins.**
Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**Ded./Coins.**	**Ded./Coins.**
Cleft Lip and Palate	**Ded./Coins.**	**Ded./Coins.**
Chiropractic Care ***Limited to 20 visits per year***	**First Visit $75 Copay; 2+ Visits: $75 Copay + Ded.**	**Ded./Coins.**
EMERGENCY CARE		

Urgent Care	**$75 Copay**	**Ded./Coins.**
Emergency Room Care	**First Visit: $250 Copay; 2+ Visits: $250 Copay + Ded.**	**First Visit: $250 Copay; 2+ Visits: $250 Copay + Ded.**
Emergency Advanced Imaging / High Tech Radiology	**Ded./Coins.**	**Ded./30% Coins.**
Emergency Transportation/ Ambulance	**Ded./Coins.**	**Ded./Coins.**
HOSPITALIZATION		
Inpatient Services	**$500 Admit + Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
Inpatient Physician and Surgical Services	**Ded./Coins.**	**Ded./Coins.**
TRANSPLANT		
Transplants	**Ded./Coins.**	**Not Covered**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visits	**$0**	**Ded./Coins.**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**One Time $250 Copay**	**Ded./Coins.**
Outpatient Ultrasound	**Ded./Coins.**	**Ded./Coins.**
All Inpatient Services/Facility Charges	**$500 Admit + Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**First Visit $75 Copay; 2+ Visits: $75 Copay + Ded.**	**Ded./Coins.**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**Ded./Coins.**	**Ded./Coins.**
Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**$500 Admit + Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**

Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Habilitation Services ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Durable Medical Equipment	**Ded./Coins.**	**Ded./Coins.**
LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**Included in PCP Office Visit**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**Ded./Coins.**
Diagnostic Mammogram		
Primary Care Physician's Office	**Ded./Coins.**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Free-Standing Facility	**Ded./Coins.**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**Ded./Coins.**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
Specialist's Office	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
Free-Standing Facility	**$250 Copay + Ded.**	**Ded./Coins.**
Outpatient	**250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**Ded./Coins.**
Preventive/Screening Mammogram		
Primary Care Physician's Office	**$0**	**Ded./Coins.**
Specialist's Office	**$0**	**Ded./Coins.**
Free-Standing Facility	**$0**	**Ded./Coins.**
Outpatient	**$0**	**Ded./Coins.**
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE		
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**	
Vision Screening for Children	**One routine eye examination per year**	
Eye Glasses for Children[I]	**One pair of standard eyeglass lenses or contact lenses per year; one frame every year**	
PRESCRIPTION DRUGS		
Pharmacy	**Separate $1,000 Rx Deductible**	
Tier 1A: Lower Cost Preferred Generic Drugs	**Preferred Pharmacy $5 / Non Preferred Pharmacy $20 / Mail Order $10**	

Tier 1: Preferred Generic Drugs	**Preferred Pharmacy $15 / Non Preferred Pharmacy $20 / Mail Order $30**
Tier 2: Preferred Brand Drugs	**Preferred Pharmacy $45 + Deductible / Non Preferred Pharmacy $55 + Deductible / Mail Order $112.50 + Deductible**
Tier 3: Non-Preferred Brand/Generic Drugs	**Preferred Pharmacy $75 + Deductible / Non Preferred Pharmacy $85 + Deductible / Mail Order $225 + Deductible**
Tier 4: Preferred Specialty Drugs	**Preferred Pharmacy Deductible + 30% Coinsurance**
Tier 5: Non-Preferred Specialty Drugs	**Preferred Pharmacy Deductible + 40% Coinsurance**

[i] Members receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

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BENEFIT CATEGORIES AND COST SHARING

Carelink from Coventry	***Bronze $10 Copay PPO Baptist***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 – Out of Network***
Annual Deductible (Ded.)	**Individual: $5,600**	**Individual: $6,400**
	Family: $11,200	**Family: $12,800**
Coinsurance (Coins.)	**30%**	**50%**
Out-of-Pocket Maximum	**Individual: $6,400**	**Individual: Unlimited**
	Family: $12,800	**Family: Unlimited**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**$10 Copay**	**Ded./Coins.**
Specialist	**$75 + Ded.**	**Ded./Coins.**
Surgery		
Primary Care Physician's Office	**Ded./Coins.**	**$250 Copay + Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**$250 Copay + Ded./Coins.**
Free-Standing Facility	**$250 Copay + Ded.**	**Ded./Coins.**
Outpatient	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
Outpatient Facility and Physician Services	**Ded./Coins.**	**Ded./Coins.**
Home Health Care/Hospice ***Limited to 60 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Skilled Nursing Facility ***Limited to 60 days per year***	**Ded./Coins.**	**Ded./Coins.**
Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**Ded./Coins.**	**Ded./Coins.**
Cleft Lip and Palate	**Ded./Coins.**	**Ded./Coins.**
Chiropractic Care ***Limited to 20 visits per year***	**$75 + Ded.**	**Ded./Coins.**
EMERGENCY CARE		
Urgent Care	**$75 Copay + Ded.**	**Ded./Coins.**
Emergency Room Care	**$500 Copay + Ded.**	**$500 Copay + Ded.**

Emergency Advanced Imaging / High Tech Radiology	**Ded./Coins.**	**Ded./ 30% Coins.**
Emergency Transportation/ Ambulance	**Ded./Coins.**	**Ded./Coins.**
HOSPITALIZATION		
Inpatient Services	**$500 Admit + Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
Inpatient Physician and Surgical Services	**Ded./Coins.**	**Ded./Coins.**
TRANSPLANT		
Transplants	**Ded./Coins.**	**Not Covered**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visits	**$0**	**Ded./Coins.**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**One Time $500 Copay**	**Ded./Coins.**
Outpatient Ultrasound	**Ded./Coins.**	**Ded./Coins.**
All Inpatient Services/Facility Charges	**$500 Admit + Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**$75 Copay + Ded.**	**Ded./Coins.**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**Ded./Coins.**	**Ded./Coins.**
Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**$500 Admit + Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Habilitation Services ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Durable Medical Equipment	**Ded./Coins.**	**Ded./Coins.**

LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**Included in PCP Office Visit**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**Ded./Coins.**
Diagnostic Mammogram		
Primary Care Physician's Office	**Ded./Coins.**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Free-Standing Facility	**Ded./Coins**	**Ded./Coins.**
Outpatient	**Ded./Coins**	**Ded./Coins.**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
Specialist's Office	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
Free-Standing Facility	**$250 Copay + Ded.**	**Ded./Coins.**
Outpatient	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**Ded./Coins.**
Preventive/Screening Mammogram		
Primary Care Physician's Office	**$0**	**Ded./Coins.**
Specialist's Office	**$0**	**Ded./Coins.**
Free-Standing Facility	**$0**	**Ded./Coins.**
Outpatient	**$0**	**Ded./Coins.**
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE		
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**	
Vision Screening for Children	**One routine eye examination per year**	
Eye Glasses for Children[I]	**One pair of standard eyeglass lenses or contact lenses per year; one frame every year**	
PRESCRIPTION DRUGS		
Pharmacy	**Integrated Medical and Rx Deductible**	
Tier 1: Preferred Generic Drugs	**Preferred Pharmacy $15 / Non Preferred Pharmacy $20 / Mail Order $30**	
Tier 2: Preferred Brand Drugs	**Preferred Pharmacy $45 + Deductible / Non Preferred Pharmacy $55 + Deductible / Mail Order $112.50 + Deductible**	

Tier 3: Non-Preferred Brand/Generic Drugs	**Preferred Pharmacy $75 + Deductible / Non Preferred Pharmacy $85 + Deductible / Mail Order $225 + Deductible**
Tier 4: Preferred Specialty Drugs	**Preferred Pharmacy Deductible + 30% Coinsurance**
Tier 5: Non-Preferred Specialty Drugs	**Preferred Pharmacy Deductible + 40% Coinsurance**

[i] Members receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

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This benefit Plan is only available for an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, with a household income less than three hundred percent (300%) of the Federal Poverty Level (FPL) and who is determined eligible to enroll in the Plan by the Health Insurance Marketplace.

BENEFIT CATEGORIES AND COST SHARING

Carelink from Coventry	***Bronze $0 Copay PPO Baptist Indian No Cost Share***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 - OON***
Annual Deductible (Ded.)	**Individual: $0**	**Individual: $0**
	Family: $0	**Family: $0**
Coinsurance (Coins.)	**0%**	**0%**
Out-of-Pocket Maximum	**Individual: $0**	**Individual: $0**
	Family: $0	**Family: $0**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**$0**	**$0**
Specialist	**$0**	**$0**
Surgery		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**
Outpatient Facility and Physician Services	**$0**	**$0**
Home Health Care/Hospice ***Limited to 60 visits per year***	**$0**	**$0**
Skilled Nursing Facility ***Limited to 60 days per year***	**$0**	**$0**
Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**$0**	**$0**

Cleft Lip and Palate	**$0**	**$0**
Chiropractic Care ***Limited to 20 visits per year***	**$0**	**$0**
EMERGENCY CARE		
Urgent Care	**$0**	**$0**
Emergency Room Care	**$0**	**$0**
Emergency Advanced Imaging / High Tech Radiology	**$0**	**$0**
Emergency Transportation/ Ambulance	**$0**	**$0**
HOSPITALIZATION		
Inpatient Services	**$0**	**$0**
Inpatient Physician and Surgical Services	**$0**	**$0**
TRANSPLANT		
Transplants	**$0**	**$0**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visits	**$0**	**$0**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**$0**	**$0**
Outpatient Ultrasound	**$0**	**$0**
All Inpatient Services/Facility Charges	**$0**	**$0**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**$0**	**$0**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**$0**	**$0**
Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**$0**	**$0**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**$0**	**$0**

Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**$0**	**$0**
Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**$0**	**$0**
Habilitation Services ***Limited to 20 visits per year***	**$0**	**$0**
Durable Medical Equipment	**$0**	**$0**
LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Outpatient	**$0**	**$0**
Diagnostic Mammogram		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**$0**
Preventive/Screening Mammogram		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE		
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**	
Vision Screening for Children	**$0**	
Eye Glasses for Children[I]	**$0**	
PRESCRIPTION DRUGS		
Pharmacy		
Tier 1A: Lower Cost Preferred Generic Drugs	**$0**	
Tier 1: Preferred Generic Drugs	**$0**	
Tier 2: Preferred Brand Drugs	**$0**	
Tier 3: Non-Preferred Brand/Generic Drugs	**$0**	

Tier 4: Preferred Specialty Drugs	**$0**
Tier 5: Non-Preferred Specialty Drugs	**$0**

[i] Members receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

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This benefit Plan is only available for an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, who is determined eligible to enroll in the Plan by the Health Insurance, and therefore is not required to pay any cost sharing on any item or service that qualifies as an essential health benefit in the Health Insurance Marketplace market if that essential health benefit is furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603).

BENEFIT CATEGORIES AND COST SHARING

Carelink from Coventry	***Bronze $10 Copay PPO Baptist Indian Provider No Cost Share***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 – Out of Network***
Annual Deductible (Ded.)	**Individual: $5,600**	**Individual: $6,400**
	Family: $11,200	**Family: $12,800**
Coinsurance (Coins.)	**30%**	**50%**
Out-of-Pocket Maximum	**Individual: $6,400**	**Individual: Unlimited**
	Family: $12,800	**Family: Unlimited**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**$10 Copay**	**Ded./Coins.**
Specialist	**$75 + Ded.**	**Ded./Coins.**
Surgery		
Primary Care Physician's Office	**Ded./Coins.**	**$250 Copay + Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**$250 Copay + Ded./Coins.**
Free-Standing Facility	**$250 Copay + Ded.**	**Ded./Coins.**
Outpatient	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
Outpatient Facility and Physician Services	**Ded./Coins.**	**Ded./Coins.**
Home Health Care/Hospice ***Limited to 60 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Skilled Nursing Facility ***Limited to 60 days per year***	**Ded./Coins.**	**Ded./Coins.**
Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**Ded./Coins.**	**Ded./Coins.**
Cleft Lip and Palate	**Ded./Coins.**	**Ded./Coins.**

Chiropractic Care ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
EMERGENCY CARE		
Urgent Care	**$75 Copay + Ded.**	**Ded./Coins.**
Emergency Room Care	**$500 Copay + Ded.**	**$500 Copay + Ded.**
Emergency Advanced Imaging / High Tech Radiology	**Ded./Coins.**	**Ded./ 30% Coins.**
Emergency Transportation/ Ambulance	**Ded./Coins.**	**Ded./Coins.**
HOSPITALIZATION		
Inpatient Services	**$500 Admit + Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
Inpatient Physician and Surgical Services	**Ded./Coins.**	**Ded./Coins.**
TRANSPLANT		
Transplants	**Ded./Coins.**	**Not Covered**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visits	**$0**	**Ded./Coins.**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**One Time $500 Copay**	**Ded./Coins.**
Outpatient Ultrasound	**Ded./Coins.**	**Ded./Coins.**
All Inpatient Services/Facility Charges	**$500 Admit + Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**$75 Copay + Ded.**	**Ded./Coins.**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**Ded./Coins.**	**Ded./Coins.**
Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**$500 Admit + Ded./Coins.**	**$1,000 Admit + Ded./Coins.**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**

Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Habilitation Services ***Limited to 20 visits per year***	**Ded./Coins.**	**Ded./Coins.**
Durable Medical Equipment	**Ded./Coins.**	**Ded./Coins.**
LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**Included in PCP Office Visit**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Outpatient	**Ded./Coins.**	**Ded./Coins.**
Diagnostic Mammogram		
Primary Care Physician's Office	**Ded./Coins.**	**Ded./Coins.**
Specialist's Office	**Ded./Coins.**	**Ded./Coins.**
Free-Standing Facility	**Ded./Coins**	**Ded./Coins.**
Outpatient	**Ded./Coins**	**Ded./Coins.**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
Specialist's Office	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
Free-Standing Facility	**$250 Copay + Ded.**	**Ded./Coins.**
Outpatient	**$250 Copay + Ded./Coins.**	**$250 Copay + Ded./Coins.**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**Ded./Coins.**
Preventive/Screening Mammogram		
Primary Care Physician's Office	**$0**	**Ded./Coins.**
Specialist's Office	**$0**	**Ded./Coins.**
Free-Standing Facility	**$0**	**Ded./Coins.**
Outpatient	**$0**	**Ded./Coins.**
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE		
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**	
Vision Screening for Children	**One routine eye examination per year**	
Eye Glasses for Children[i]	**One pair of standard eyeglass lenses or contact lenses per year; one frame every year**	
PRESCRIPTION DRUGS		
Pharmacy	**Integrated Medical and Rx Deductible**	

Tier 1: Preferred Generic Drugs	**Preferred Pharmacy $15 / Non Preferred Pharmacy $20 / Mail Order $30**
Tier 2: Preferred Brand Drugs	**Preferred Pharmacy $45 + Deductible / Non Preferred Pharmacy $55 + Deductible / Mail Order $112.50 + Deductible**
Tier 3: Non-Preferred Brand/Generic Drugs	**Preferred Pharmacy $75 + Deductible / Non Preferred Pharmacy $85 + Deductible / Mail Order $225 + Deductible**
Tier 4: Preferred Specialty Drugs	**Preferred Pharmacy Deductible + 30% Coinsurance**
Tier 5: Non-Preferred Specialty Drugs	**Preferred Pharmacy Deductible + 40% Coinsurance**

[i] Members receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

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BENEFIT CATEGORIES AND COST SHARING

Carelink from Coventry	***Bronze Deductible Only HSA Eligible PPO Baptist***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 – Out of Network***
Annual Deductible (Ded.)	**Individual: $6,300**	**Individual: $6,400**
	Family: $12,600	**Family: $12,800**
Coinsurance (Coins.)	**0%**	**50%**
Out-of-Pocket Maximum	**Individual: $6,300**	**Individual: Unlimited**
	Family: $12,600	**Family: Unlimited**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**Ded.**	**Ded./Coins.**
Specialist	**Ded.**	**Ded./Coins.**
Surgery		
Primary Care Physician's Office	**Ded.**	**Ded./$250 Copay/Coins.**
Specialist's Office	**Ded.**	**Ded./$250 Copay/Coins.**
Free-Standing Facility	**Ded.**	**Ded./Coins.**
Outpatient	**Ded.**	**Ded./$250 Copay/Coins.**
Outpatient Facility and Physician Services	**Ded.**	**Ded./Coins.**
Home Health Care/Hospice ***Limited to 60 visits per year***	**Ded.**	**Ded./Coins.**
Skilled Nursing Facility ***Limited to 60 days per year***	**Ded.**	**Ded./Coins.**
Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**Ded.**	**Ded./Coins.**
Cleft Lip and Palate	**Ded.**	**Ded./Coins.**
Chiropractic Care ***Limited to 20 visits per year***	**Ded.**	**Ded./Coins.**
EMERGENCY CARE		
Urgent Care	**Ded.**	**Ded./Coins.**
Emergency Room Care	**Ded.**	**Ded.**
Emergency Advanced Imaging / High Tech Radiology	**Ded.**	**Ded.**
Emergency Transportation/ Ambulance	**Ded.**	**Ded./Coins.**

HOSPITALIZATION		
Inpatient Services	**Ded.**	**Ded./$1,000 Admit/Coins.**
Inpatient Physician and Surgical Services	**Ded.**	**Ded./Coins.**
TRANSPLANT		
Transplants	**Ded.**	**Not Covered**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visits	**$0**	**Ded./Coins.**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**Ded.**	**Ded./Coins.**
Outpatient Ultrasound	**Ded.**	**Ded./Coins.**
All Inpatient Services/Facility Charges	**Ded.**	**Ded./$1,000 Admit/Coins.**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**Ded.**	**Ded./Coins.**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**Ded.**	**Ded./Coins.**
Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**Ded.**	**Ded./$1,000 Admit/Coins.**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**Ded.**	**Ded./Coins.**
Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**Ded.**	**Ded./Coins.**
Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**Ded.**	**Ded./Coins.**
Habilitation Services ***Limited to 20 visits per year***	**Ded.**	**Ded./Coins.**
Durable Medical Equipment	**Ded.**	**Ded./Coins.**
LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**Ded.**	**Ded./Coins.**
Specialist's Office	**Ded.**	**Ded./Coins.**
Outpatient	**Ded.**	**Ded./Coins.**
Diagnostic Mammogram		
Primary Care Physician's Office	**Ded.**	**Ded./Coins.**

Specialist's Office	**Ded.**	**Ded./Coins.**
Free-Standing Facility	**Ded.**	**Ded./Coins.**
Outpatient	**Ded.**	**Ded./Coins.**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**Ded.**	**Ded./$250 Copay/Coins.**
Specialist's Office	**Ded.**	**Ded./$250 Copay/Coins.**
Free-Standing Facility	**Ded.**	**Ded./Coins.**
Outpatient	**Ded.**	**Ded./$250 Copay/Coins.**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**Ded./Coins.**
Preventive/Screening Mammogram		
Primary Care Physician's Office	**$0**	**Ded./Coins.**
Specialist's Office	**$0**	**Ded./Coins.**
Free-Standing Facility	**$0**	**Ded./Coins.**
Outpatient	**$0**	**Ded./Coins.**
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE		
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**	
Vision Screening for Children	**One routine eye examination per year**	
Eye Glasses for Children[i]	**Ded. - One pair of standard eyeglass lenses or contact lenses per year; one frame every year**	
PRESCRIPTION DRUGS		
Pharmacy	**Integrated Medical / Rx Deductible**	
Tier 1: Preferred Generic Drugs	**Deductible**	
Tier 2: Preferred Brand Drugs	**Deductible**	
Tier 3: Non-Preferred Brand/Generic Drugs	**Deductible**	
Tier 4: Preferred Specialty Drugs	**Deductible**	
Tier 5: Non-Preferred Specialty Drugs	**Deductible**	

[i] Members receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

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BENEFIT CATEGORIES AND COST SHARING

Carelink from Coventry	***Bronze Deductible Only PPO Baptist Indian No Cost Share***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 - OON***
Annual Deductible (Ded.)	**Individual: $0**	**Individual: $0**
	Family: $0	**Family: $0**
Coinsurance (Coins.)	**0%**	**0%**
Out-of-Pocket Maximum	**Individual: $0**	**Individual: $0**
	Family: $0	**Family: $0**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**$0**	**$0**
Specialist	**$0**	**$0**
Surgery		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**
Outpatient Facility and Physician Services	**$0**	**$0**
Home Health Care/Hospice ***Limited to 60 visits per year***	**$0**	**$0**
Skilled Nursing Facility ***Limited to 60 days per year***	**$0**	**$0**
Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**$0**	**$0**

Cleft Lip and Palate	**$0**	**$0**
Chiropractic Care ***Limited to 20 visits per year***	**$0**	**$0**
EMERGENCY CARE		
Urgent Care	**$0**	**$0**
Emergency Room Care	**$0**	**$0**
Emergency Advanced Imaging / High Tech Radiology	**$0**	**$0**
Emergency Transportation/ Ambulance	**$0**	**$0**
HOSPITALIZATION		
Inpatient Services	**$0**	**$0**
Inpatient Physician and Surgical Services	**$0**	**$0**
TRANSPLANT		
Transplants	**$0**	**$0**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visits	**$0**	**$0**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**$0**	**$0**
Outpatient Ultrasound	**$0**	**$0**
All Inpatient Services/Facility Charges	**$0**	**$0**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**$0**	**$0**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**$0**	**$0**
Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**$0**	**$0**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**$0**	**$0**

Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**$0**	**$0**
Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**$0**	**$0**
Habilitation Services ***Limited to 20 visits per year***	**$0**	**$0**
Durable Medical Equipment	**$0**	**$0**
LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Outpatient	**$0**	**$0**
Diagnostic Mammogram		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**$0**
Preventive/Screening Mammogram		
Primary Care Physician's Office	**$0**	**$0**
Specialist's Office	**$0**	**$0**
Free-Standing Facility	**$0**	**$0**
Outpatient	**$0**	**$0**
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE		
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**	
Vision Screening for Children	**$0**	
Eye Glasses for Children[I]	**$0**	
PRESCRIPTION DRUGS		
Pharmacy		
Tier 1A: Lower Cost Preferred Generic Drugs	**$0**	
Tier 1: Preferred Generic Drugs	**$0**	
Tier 2: Preferred Brand Drugs	**$0**	
Tier 3: Non-Preferred Brand/Generic Drugs	**$0**	

Tier 4: Preferred Specialty Drugs	**$0**
Tier 5: Non-Preferred Specialty Drugs	**$0**

[i] Members receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

COVENTRY
Health and Life Insurance Company

5350 Poplar Ave, Suite 390 Memphis, Tennessee 38119
1-855-449-2889
www.chctn.com

This Schedule of Benefits, Covered Services, and Exclusions is part of your Individual Member Contract but does not replace it. Many words are defined elsewhere in the Contract, and other limitations or exclusions may be listed in other sections of your Contract. Reading this Schedule by itself could give you an inaccurate impression of the terms of your coverage. This Schedule must be read with the rest of your Contract. Prior authorization may be required for specific services.

This benefit Plan is only available for an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, who is determined eligible to enroll in the Plan by the Health Insurance, and therefore is not required to pay any cost sharing on any item or service that qualifies as an essential health benefit in the Health Insurance Marketplace market if that essential health benefit is furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603).

BENEFIT CATEGORIES AND COST SHARING

Carelink from Coventry	***Bronze Deductible Only PPO Baptist Indian Provider No Cost Share***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 – Out of Network***
Annual Deductible (Ded.)	**Individual: $6,300**	**Individual: $6,400**
	Family: $12,600	**Family: $12,800**
Coinsurance (Coins.)	**0%**	**50%**
Out-of-Pocket Maximum	**Individual: $6,300**	**Individual: Unlimited**
	Family: $12,600	**Family: Unlimited**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**Ded.**	**Ded./Coins.**
Specialist	**Ded.**	**Ded./Coins.**
Surgery		
Primary Care Physician's Office	**Ded.**	**Ded./$250 Copay/Coins.**
Specialist's Office	**Ded.**	**Ded./$250 Copay/Coins.**
Free-Standing Facility	**Ded.**	**Ded./Coins.**
Outpatient	**Ded.**	**Ded./$250 Copay/Coins.**
Outpatient Facility and Physician Services	**Ded.**	**Ded./Coins.**
Home Health Care/Hospice ***Limited to 60 visits per year***	**Ded.**	**Ded./Coins.**
Skilled Nursing Facility ***Limited to 60 days per year***	**Ded.**	**Ded./Coins.**
Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**Ded.**	**Ded./Coins.**
Cleft Lip and Palate	**Ded.**	**Ded./Coins.**
Chiropractic Care ***Limited to 20 visits per year***	**Ded.**	**Ded./Coins.**

EMERGENCY CARE		
Urgent Care	**Ded.**	**Ded./Coins.**
Emergency Room Care	**Ded.**	**Ded.**
Emergency Advanced Imaging / High Tech Radiology	**Ded.**	**Ded.**
Emergency Transportation/ Ambulance	**Ded.**	**Ded./Coins.**
HOSPITALIZATION		
Inpatient Services	**Ded.**	**Ded./$1,000 Admit/Coins.**
Inpatient Physician and Surgical Services	**Ded.**	**Ded./Coins.**
TRANSPLANT		
Transplants	**Ded.**	**Not Covered**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visits	**$0**	**Ded./Coins.**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**Ded.**	**Ded./Coins.**
Outpatient Ultrasound	**Ded.**	**Ded./Coins.**
All Inpatient Services/Facility Charges	**Ded.**	**Ded./$1,000 Admit/Coins.**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**Ded.**	**Ded./Coins.**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**Ded.**	**Ded./Coins.**
Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**Ded.**	**Ded./$1,000 Admit/Coins.**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**Ded.**	**Ded./Coins.**
Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**Ded.**	**Ded./Coins.**

Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**Ded.**	**Ded./Coins.**
Habilitation Services ***Limited to 20 visits per year***	**Ded.**	**Ded./Coins.**
Durable Medical Equipment	**Ded.**	**Ded./Coins.**
LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**Ded.**	**Ded./Coins.**
Specialist's Office	**Ded.**	**Ded./Coins.**
Outpatient	**Ded.**	**Ded./Coins.**
Diagnostic Mammogram		
Primary Care Physician's Office	**Ded.**	**Ded./Coins.**
Specialist's Office	**Ded.**	**Ded./Coins.**
Free-Standing Facility	**Ded.**	**Ded./Coins.**
Outpatient	**Ded.**	**Ded./Coins.**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**Ded.**	**Ded./$250 Copay/Coins.**
Specialist's Office	**Ded.**	**Ded./$250 Copay/Coins.**
Free-Standing Facility	**Ded.**	**Ded./Coins.**
Outpatient	**Ded.**	**Ded./$250 Copay/Coins.**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**Ded./Coins.**
Preventive/Screening Mammogram		
Primary Care Physician's Office	**$0**	**Ded./Coins.**
Specialist's Office	**$0**	**Ded./Coins.**
Free-Standing Facility	**$0**	**Ded./Coins.**
Outpatient	**$0**	**Ded./Coins.**
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE		
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**	
Vision Screening for Children	**One routine eye examination per year**	
Eye Glasses for Children[l]	**Ded. - One pair of standard eyeglass lenses or contact lenses per year; one frame every year**	
PRESCRIPTION DRUGS		
Pharmacy	**Integrated Medical / Rx Deductible**	
Tier 1: Preferred Generic Drugs	**Deductible**	
Tier 2: Preferred Brand Drugs	**Deductible**	

Tier 3: Non-Preferred Brand/Generic Drugs	**Deductible**
Tier 4: Preferred Specialty Drugs	**Deductible**
Tier 5: Non-Preferred Specialty Drugs	**Deductible**

[i] Members receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

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BENEFIT CATEGORIES AND COST SHARING

Carelink from Coventry	***Catastrophic 100% PPO Baptist***	
Benefits	Member pays	
	Tier One – Limited network (HPN)	***Tier 2 – Out of Network***
Annual Deductible (Ded.)	**Individual: $6,400**	**Individual: $6,400**
	Family: $12,800	**Family: $12,800**
Coinsurance (Coins.)	**0%**	**50%**
Out-of-Pocket Maximum	**Individual: $6,400**	**Individual: Unlimited**
	Family: $12,800	**Family: Unlimited**
AMBULATORY SERVICES		
Office Visit		
Primary Care Physician	**First 3 visits: $20 Copay; 4+ visits: Ded.**	**Ded./Coins.**
Specialist	**Ded.**	**Ded./Coins.**
Surgery		
Primary Care Physician's Office	**Ded.**	**Ded./Coins.**
Specialist's Office	**Ded.**	**Ded./Coins.**
Free-Standing Facility	**Ded.**	**Ded./Coins.**
Outpatient	**Ded.**	**Ded./Coins.**
Outpatient Facility and Physician Services	**Ded.**	**Ded./Coins.**
Home Health Care/Hospice ***Limited to 60 visits per year***	**Ded.**	**Ded./Coins.**
Skilled Nursing Facility ***Limited to 60 days per year***	**Ded.**	**Ded./Coins.**
Hearing Aids ***Limited to one (1) hearing aid device per ear, every 3 years***	**Ded.**	**Ded./Coins.**
Cleft Lip and Palate	**Ded.**	**Ded./Coins.**
Chiropractic Care ***Limited to 20 visits per year***	**Ded.**	**Ded./Coins.**
EMERGENCY CARE		
Urgent Care	**Ded.**	**Ded./Coins.**
Emergency Room Care	**Ded.**	**Ded.**
Emergency Advanced Imaging / High Tech Radiology	**Ded.**	**Ded.**

Emergency Transportation/ Ambulance	**Ded.**	**Ded./Coins.**
HOSPITALIZATION		
Inpatient Services	**Ded.**	**Ded./Coins.**
Inpatient Physician and Surgical Services	**Ded.**	**Ded./Coins.**
TRANSPLANT		
Transplants	**Ded.**	**Not Covered**
MATERNITY AND NEWBORN CARE		
Prenatal Office Visits	**$0**	**Ded./Coins.**
Physician Charges, Prenatal, Postnatal, Ultrasound, Delivery	**Ded.**	**Ded./Coins.**
Outpatient Ultrasound	**Ded.**	**Ded./Coins.**
All Inpatient Services/Facility Charges	**Ded.**	**Ded./Coins.**
MENTAL HEALTH/SUBSTANCE ABUSE DISORDER SERVICES INCLUDING BEHAVIORAL HEALTH MANAGEMENT		
Office	**Ded.**	**Ded./Coins.**
Outpatient/Partial Hospitalization ***Limited to 25 visits per year combined Mental Health and Substance Abuse***	**Ded.**	**Ded./Coins.**
Inpatient ***Limited to 20 days per year combined Mental Health and Substance Abuse***	**Ded.**	**Ded./Coins.**
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
Outpatient Rehabilitation Services ***Limited to 20 visits per year***	**Ded.**	**Ded./Coins.**
Rehabilitative Speech Therapy ***Limited to 20 visits per year***	**Ded.**	**Ded./Coins.**
Rehabilitative Occupational and Rehabilitative Physical Therapy ***Limited to 40 visits per year***	**Ded.**	**Ded./Coins.**
Habilitation Services ***Limited to 20 visits per year***	**Ded.**	**Ded./Coins.**
Durable Medical Equipment	**Ded.**	**Ded./Coins.**
LAB SERVICES		
Lab/Radiology		
Primary Care Physician's Office	**Ded.**	**Ded./Coins.**

Specialist's Office	**Ded.**	**Ded./Coins.**
Outpatient	**Ded.**	**Ded./Coins.**
Diagnostic Mammogram		
Primary Care Physician's Office	**Ded.**	**Ded./Coins.**
Specialist's Office	**Ded.**	**Ded./Coins.**
Free-Standing Facility	**Ded.**	**Ded./Coins.**
Outpatient	**Ded.**	**Ded./Coins.**
Advanced Imaging / High Tech Radiology		
Primary Care Physician's Office	**Ded.**	**Ded./Coins.**
Specialist's Office	**Ded.**	**Ded./Coins.**
Free-Standing Facility	**Ded.**	**Ded./Coins.**
Outpatient	**Ded.**	**Ded./Coins.**
PREVENTION/WELLNESS		
Preventive Care/Screening/ Immunization	**$0**	**Ded./Coins.**
Preventive/Screening Mammogram		
Primary Care Physician's Office	**$0**	**Ded./Coins.**
Specialist's Office	**$0**	**Ded./Coins.**
Free-Standing Facility	**$0**	**Ded./Coins.**
Outpatient	**$0**	**Ded./Coins.**
PEDIATRIC SERVICES INCLUDING ORAL AND VISION CARE		
Dental Check-up for Children	**Not required due to Stand Alone Dental Product (SADP).**	
Vision Screening for Children	**One routine eye examination per year**	
Eye Glasses for Children[I]	**One pair of standard eyeglass lenses or contact lenses per year; one frame every year**	
PRESCRIPTION DRUGS		
Pharmacy	**Integrated Medical / Rx Deductible**	
Tier 1: Preferred Generic Drugs	**Deductible**	
Tier 2: Preferred Brand Drugs	**Deductible**	
Tier 3: Non-Preferred Brand/Generic Drugs	**Deductible**	
Tier 4: Preferred Specialty Drugs	**Deductible**	
Tier 5: Non-Preferred Specialty Drugs	**Deductible**	

[i] Members receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

COVENTRY HEALTH AND LIFE INSURANCE COMPANY

Carelink from Coventry

PREFERRED PROVIDER ORGANIZATION ("PPO")

INDIVIDUAL MEMBER CONTRACT AVAILABLE IN THE HEALTH INSURANCE MARKETPLACE

Under this PPO Plan, inpatient, outpatient and other Covered Services are available through both In-Network (Participating) Providers and Out-of-Network (Non-Participating) Providers. Benefits under this Plan are subject to Our Utilization Management Program.

Keep in mind that using a Participating Provider (Your In-Network benefits) will usually cost You less than using a Non-Participating Provider (Your Out-of-Network benefits) because Participating Providers are Contracted with Us to provide health care services to Members for a lower fee, whereas Non-Participating Providers are not Contracted with Us. Please see Section 1 for more information on how Your In-Network and Out-of-Network benefits work.

Dear New Member:

Welcome to Coventry Health and Life Insurance Company! We are extremely pleased that You have enrolled in Our Carelink from Coventry Plan and look forward to serving You.

Coventry is a subsidiary of Coventry Health Care, Inc., a Fortune 500 company operating Plans, insurance companies, Network rental, and workers' compensation services companies in all 50 states and Puerto Rico. We are one of the country's largest managed health care companies providing a full range of risk and fee-based health care products and services.

Coventry Health Care's Plans emphasize wellness and preventive care. You will find that Our strong Network of area Physicians, Hospitals, and other Providers offers a broad range of services to meet Your medical needs.

As a Coventry Health Care Member, it is important that You understand the way Your Plan operates. This Individual Member Contract is an important legal document and contains the information You need to know about Your Coverage with Us and how to get the care You need. Please keep it in a safe place where You can refer to it as needed.

Please take a few minutes to read these materials and to make Your Covered family Members aware of the provisions of Your Coverage. Our Customer Services Department is available to answer any questions You may have about Your Coverage. You can reach them at **855-449-2889** Monday through Friday, [8:00 a.m. to 6:00 p.m. ET.] You may also access Your benefit information 24 hours a day, seven days a week by registering and logging in at www.chctn.com.

We look forward to serving You and Your family.

Yours very truly,

J Pegues
Chief Executive Officer
Coventry Health and Life Insurance Company, Inc.

COVENTRY HEALTH AND LIFE INSURANCE COMPANY.
INDIVIDUAL MEMBER CONTRACT AVAILABLE IN THE HEALTH INSURANCE MARKET PLACE

The individual Contract (hereinafter referred to as the "Contract") between Coventry Health and Life Insurance Company. (hereafter referred to as the "Health Plan", "CHL", "We", "Us", or "Our") and You is made up of the following documents:

- Individual Member Contract and any Contract amendments;
- Schedule of Benefits; and
- Applicable Riders

This is to certify that, in consideration for and upon payment of the Premium rate, the individual(s) Covered under this Contract are entitled to the benefits set forth under the terms and conditions in this Contract. The laws of the State of Tennessee govern this Contract. This Contract is a legal document. The Covered Services and provisions described in this Contract are effective only while You are eligible for Coverage under the Contract and while the Contract is in effect. You may enroll and remain enrolled under the Contract if You meet the eligibility requirements described in Section 2 of this Individual Member Contract. This Contract is renewable and may only be non-renewed and/or terminated) as set forth in Section 3. You are subject to all terms, conditions, limitations, and Exclusions in this Contract and to all of the rules and regulations of the Health Plan. By paying Premiums or having Premiums paid on Your behalf, You accept the provisions of this Contract.

This Contract gives You access to both In-Network benefits, provided by Participating Providers, and Out-of-Network benefits, provided by Non-Participating Providers. Keep in mind that using Out-of-Network Benefits may cost You more than using In-Network benefits. Please read Section 1 to learn more about how Your In-Network and Out-of-Network benefits work, or call Our Customer Service Department at 855-449-2889 if You have any questions.

THIS CONTRACT SHOULD BE READ AND RE-READ IN ITS ENTIRETY

Many of the provisions of this Contract are interrelated. Therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Contract have special meanings. These words will appear capitalized and are defined for You in Section 12. By using these definitions, You will have a clearer understanding of Your Coverage. From time to time, the Contract may be amended, as required by and in accordance with state and federal law. When this occurs, We will provide an Amendment or new Contract to You. You should keep this document in a safe place for Your future reference.

HEALTH CARE REFORM

Coventry Health and Life Insurance Company are in compliance with PPACA. If any provision of PPACA conflicts with any of the provisions of this Contract, the Contract will be interpreted to be compliant with PPACA.

COVENTRY HEALTH AND LIFE INSURANCE COMPANY
5350 Poplar Ave, Suite 390
Memphis, Tennessee 38119
855-449-2889

SPECIAL NOTICES

NOTICE TO QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN MEMBERS (HSA NOTICE)

If You enrolled in a qualified High Deductible Health Plan ("HDHP") that is HSA-compatible, please read this important notice:

The Coventry Health and Life Insurance Company. High Deductible Plan is designed to be a Federally qualified High Deductible Health Plan compatible with Health Savings Accounts ("HSA's"). Enrollment in an HDHP that is HSA-compatible is only one of the eligibility requirements for establishing and contributing to an HSA.

Please note that if You have other health Coverage in addition to the Coverage under this Contract, in most instances You may not be eligible to establish or contribute to an HSA, unless both Coverages qualify as High Deductible Health Plans.

Coventry Health and Life Insurance Company does not provide tax advice. The Tennessee Department of Insurance does NOT in any way warrant that this Plan meets the federal requirements.

Please consult with Your financial or legal advisor for information about Your eligibility for an HSA.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health Plans and Health Insurance issuers offering group Health Insurance Coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending Provider (e.g., Your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, Plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan or issuer may not, under federal law, require that You, Your Physician, or other health care Provider obtain Authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, You may be required to obtain precertification for any days of confinement that exceeds 48 hours (or 96 hours). For information on precertification, contact Your Plan administrator.

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under this Health Plan, Coverage will be provided to a person who is receiving benefits for a Medically Necessary mastectomy and who elects breast reconstruction after the mastectomy for:

(1) reconstruction of the breast on which a mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) prostheses; and

(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This Coverage will be provided in consultation with the attending Physician and the patient, and will be subject to the same annual Deductibles and Coinsurance provisions that apply for the mastectomy. If You have any questions about our Coverage of mastectomies and Reconstructive Surgery, please contact the Member Services number on Your ID card.

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SECTION 1
USING YOUR BENEFITS

Carelink from Coventry ("Carelink") is designed as a new model for delivering quality care health care services to You while keeping Your costs down. This Contract provides You with an exclusive Network of providers that includes the Carelink [Hospital Partner] Network of Participating Providers and those Specialist Participating Providers Participating in the Carelink [Hospital Partner] product. The Carelink [Hospital Partner] will have in place: a sufficient number of Primary Care Physicians who will assist You in coordinating Your care so that there is less duplication of services; leadership and management structures, including clinical and administrative systems; and processes to promote evidence-based medicine and patient engagement, report on quality and cost measures and coordinate care, such as through the use of telemedicine, remote patient monitoring and other enabling technologies. Our Participating Provider Network (hereafter referred to as the "Network") may change from time to time. Please visit Our website at http://tn.coventryproviders.com/, or You may call Our Customer Service Department at 855-449-2889 in order to find out if a Provider is a Participating Provider.

If a Provider does not have a Contractual agreement with Us, the Provider is considered to be a Non-Participating Provider.

Keep in mind that using a Participating Provider (Your In-Network benefits) may cost You less than using a Non-Participating Provider (Your Out-of-Network benefits). If services are provided to You by a Non-Participating Provider, those services will be paid at the Out-of-Network level using the Out-of-Network Rate ("ONR"). Please see Section 1.7.2 for more information on Out-of-Network Providers and the ONR.

If You receive Covered Services at an In-Network Hospital or outpatient Facility, You might inadvertently receive some services from Non-Participating Providers. In this instance, We will pay the In-Network level for Covered Services provided by a Non-Participating Pathologist, Anesthesiologist, Radiologist, Lab or Emergency Room Physician.

1.1 Membership Identification (ID) Card.

Every Plan Member receives a Membership ID card. Please carry Your Member ID card with You at all times, and present it before health care services are rendered. If Your Member ID card is missing, lost, or stolen, contact Our Customer Service Department at **855-449-2889** or visit Our website at www.chctn.com to order a replacement.

1.2 Your Primary Care Physician (PCP).

You must choose a PCP for Yourself and each Member of Your family. You may select Your PCP by calling the Customer Service phone number located on Your ID card or by visiting Our website at http://member.cvty.com,You have the right to designate any Primary Care Provider, who participates in Our Network and is available to accept You or Your family Members. If applicable to Your Plan, the name and phone number of the PCP You select will be listed on Your Member ID card.

The role of the PCP is important to the coordination of Your care, and You are encouraged to contact Your PCP when medical care is needed. This may include preventive health services, consultation with Specialists and other Providers, Emergency Services, and Urgent Care.

You can select a PCP from one of the following specialties: Family Practice, Internal Medicine, General Practice, OB/GYN, or Pediatrics. You may choose one PCP for the entire family, or each Dependent may select a different PCP. To locate the most current Directory of Health Care Providers, please visit Our website at http://tn.coventryproviders.com/. Our online Provider Directory is updated at least monthly.

If a PCP is required per Your Plan documents, and You wish to change Your PCP, You must contact Our Customer Service Department at **855-449-2889**. You may also visit Our website at

http://member.cvty.com, to make this change.

1.3 Prior Authorizations and Utilization Management.

You must comply with all of the Utilization Management Program policies and procedures noted in this Section. Our Utilization Management Program is designed to help You receive Medically Necessary Health Care in a timely manner and at the most reasonable cost. It is an effective measure in helping to monitor the quality and cost-effectiveness of Your health care.

Our Utilization Management nurses review requests for non-emergent Hospital admissions, outpatient surgeries, and other outpatient procedures. Our nurses also monitor the care You receive during a Hospital stay and post discharge.

General Policies. The following policies apply to both In-Network and Out-of-Network services:

- **Except for Emergencies, all Hospitalizations and most outpatient procedures require Prior Authorization.** You must ask Your Provider to contact Us at least two (2) days prior to a scheduled Hospital admission, outpatient surgery, or other outpatient procedure (except for emergencies) to obtain Prior Authorization. If You are admitted to a Facility prior to the date Authorized by Us, then You will be responsible for all charges related to the unauthorized days.
- **We will Authorize only Medically Necessary Covered Services.** If You obtain services, which are not Medically Necessary or the services are not Authorized by Us, then You will be responsible for all charges for those services.
- You are responsible for obtaining a referral from Your PCP for all Covered Services rendered by a Specialist. This requirement does not apply to Emergency Services, obstetrical and gynecological care from an In-Network Provider and mental health and substance abuse services from an In-Network Provider. You or Your PCP must provide notice of the referral to the Health Plan prior to services being rendered by the Specialist. If a PCP referral is required and You do not obtain one, the services rendered by the Specialist will not be Covered under the Contract. Please be aware that obtaining a referral is not itself a guarantee of payment for services]
- **Intentional material misrepresentation:** If We Authorize a service that We later determine was based on an intentional material misrepresentation about Your health status, payment of the service will be denied. You will be responsible for all charges related to that service.
- **Notification letter:** When We approve or deny a Prior Authorization request, We will send a notification letter to You and Your Provider.
- **Right to Appeal:** You have the right to Appeal any Utilization Management Program denial regarding Medical Necessity. Please see the Appeal procedures in Section 7.
- **Attending Physician responsibility:** Under all circumstances, the attending Physician bears the ultimate responsibility for the medical decisions regarding Your treatment.
- **Prior Authorization requirements are subject to change from time to time.** Please ask Your Provider to call Customer Service at **855-449-2889** to determine whether a Covered Service requires Prior Authorization. The Prior Authorization phone number is located on the back of Your Member ID Card.

It is Your responsibility to ensure that Your Provider contacts us to obtain Prior Authorization. Please call Our Customer Service Department at 855-449-2889 to determine whether a Covered Service requires Prior Authorization.

1.4 Access to Services.

We make every effort to ensure that Your access to Covered Services is quick and easy and the services are reasonably available. If You wish to see a particular Provider that is not accepting new patients or is no longer Participating in Our Network, please call Our Customer Service Department at **855-449-2889**. We can help You find another Participating Provider that meets Your needs. You may also nominate Your Non-Participating Provider to become a Participating Provider with Coventry, or You may nominate Your Non-Participating Provider under the Consumer Choice Option. Please call Our Customer Service Department for more information.

Continuity of care is especially important to Us. If Your Participating Provider unexpectedly stops Participating with Us while You are in the middle of treatment, please call Us so We can help You continue treatment with another Participating Provider. If You are suffering from a terminal or chronic illness or are an inpatient, We will allow You to continue Your treatment with Your Non-Participating Provider. In this case, We will continue to pay for the Covered Services You receive from Your Non-Participating Provider for one hundred and twenty (120) days following the Provider's termination from Our Network.

1.5 Copayments, Coinsurance, and Deductibles

Your Copayment, Coinsurance, and Deductible amounts are listed in Your Schedule of Benefits. You are responsible for paying Copayments to Your Provider at the time of service. Coinsurance and Deductible amounts, based on the Health Plan's reimbursement to the Provider, may be due to the Provider before or at the time of service. The typical order of payment of these amounts on claims is as follows: Copayments are applied first, Deductible's are applied second, and Coinsurance's are applied last. However, please be aware that Your specific Plan may have different rules. Please see Your Schedule of Benefits for the specific rules of Your Plan.

In-Network. If You receive In-Network Covered Services, You are responsible only for the applicable Copayment, Deductible, and/or Coinsurance amounts noted in Your Schedule of Benefits.

Out-of-Network. If You receive Out-of-Network Covered Services, You are responsible for the applicable Copayment, Deductible, and/or Coinsurance amounts noted in Your Schedule of Benefits, plus any amount in excess of the Out-of-Network Rate ("ONR"). Please see Section 1.7 for more information on the Out-of Network Rate and Your potential Out-of-Network liability.

Individual Deductible. The Individual Deductible applies when only one Member is enrolled in Your Plan. For services subject to the Individual Deductible, You must satisfy Your entire calendar year Individual Deductible before the Health Plan will pay for Your Covered Services. After Your Individual Deductible is satisfied, the Health Plan will pay for Your Covered Services, minus any applicable Copayments or Coinsurance. Please refer to the Schedule of Benefits, Covered Services, and Exclusions for details on Your Individual Deductible. For a family plan, there is no Individual Deductible and the Family Deductible applies.

Family Deductible. The Family Deductible applies when two or more Members are enrolled in Your Plan. For services subject to the Family Deductible, the entire calendar year Family Deductible must be satisfied before the Health Plan will pay for Covered Services for any Member. The Family Deductible is met by any combination of Members meeting the total Family calendar year Deductible. After the Family Deductible is satisfied, the Health Plan will pay for each Member's Covered Services, minus any applicable Copayments or Coinsurance. Please refer to the Schedule of Benefits, Covered Services, and Exclusions for details on your Family Deductible.

A "Discounted Charge" is the amount that a Provider has agreed to accept as payment in full for Covered Services. A "Discounted Charge" does not include pharmaceutical rebates or any other reductions, fees or credits a Provider may periodically give Us. We will retain those amounts that are not "Discounted Charges." However, We have taken those into consideration in setting the fees

charged to provide services under this Plan.

Claims under the Plan and any Deductible, Copayment, Coinsurance and the Out of Pocket maximum as described in this Contract will be determined based on the Discounted Charge.

1.6 Out-of-Pocket Maximum (OOP).

The individual Out-of-Pocket Maximum is the total amount each Member must pay out of his or her pocket annually for In-Network Covered Services. The family Out-of-Pocket Maximum is the total amount family Members must pay out of pocket annually for In-Network Covered Services. The individual Out-of-Pocket Maximum applies when only one Member is enrolled in the Plan. The family Out-of-Pocket Maximum applies when two or more Members are enrolled in the Plan. Generally speaking, out-of-pocket expenses that accumulate to the Out-of-Pocket Maximum include deductibles, coinsurance, or copayments. The Out-of-Pocket Maximum amounts are listed in the Schedule of Benefits, Covered Services, and Exclusions. Please note that there is no Out-of-Pocket Maximum for Out-of-Network Covered Services.

1.7 Payment to Providers.

1.7.1 In-Network Providers (Participating Providers).

For In-Network Covered Services, the Participating Provider will bill the Health Plan directly for the services. You do not have to file any claims for these services.

You are responsible for payment of:

A. The applicable In-Network Copayment, Deductible, and/or Coinsurance amounts;

B. Services that require Prior Authorization, which were not Prior Authorized;

C. Services that are not Medically Necessary; and

D. Services that are not Covered Services.

1.7.2 Out-of-Network Providers (Non-Participating Providers).

For Out-of-Network Covered Services, the Non-Participating Provider typically expects You to pay for the services. If so, You should submit a claim to Us for reimbursement **within twelve (12) months** and We will send the payment directly to You. However, if You assign payment of the services to the Non-Participating Provider, We will send the payment to the Non-Participating Provider.

Our payment for Out-of-Network Covered Services is limited to the **Out-of-Network Rate**, less the applicable Out-of-Network Copayment, Deductible, and/or Coinsurance amounts You are required to pay under Your Plan.

Out-of-Network Rate (ONR). The ONR is the Allowed Amount for charges billed by Non-Participating Providers. The ONR is based on a percentage of what Medicare would pay the same Provider for the same service.

If the amount You are billed by a Non-Participating Provider is equal to or less than the ONR amount, the charges should be completely Covered by Us, except for any Out-of-Network Copayment, Deductible, and/or Coinsurance amounts You are required to pay under Your Plan. However, if the amount You are billed by the Out-of-Network Provider is greater than the ONR amount, You must pay the amount in excess of the ONR amount, in addition to Your Copayment, Deductible, and/or Coinsurance amounts.

Please Remember

In addition to the Out-of-Network Copayment, Deductible, and/or Coinsurance amounts that You are required to pay for Out-of-Network Covered Services,
You are also responsible for paying the billed charges that exceed the ONR amount We pay Non-Participating Providers.

This excess amount may be substantial.

Here is an example of what Your costs could be using an In-Network Participating Provider under the scenario detailed below.

IN-NETWORK RULES	IN-NETWORK AMOUNTS
(A) Total amount billed by the Participating Provider for a procedure:	$12,000
(B) Our Allowed Amount for the procedure, as indicated in the In-Network Provider's Contract with Us:	$10,000
Your In-Network Deductible:	$2,000
(C) We subtract Your Deductible from (B):	$10,000 - $2,000 = $8,000
Your In-Network Coinsurance:	30%
(D) We apply Your Coinsurance to (C):	30% of $8,000 = $2,400
Difference between (A) and (B): **PLEASE NOTE:** Because We have a Contract with the Participating Provider, You are not responsible for paying the difference between the total billed amount and the Allowed Amount.	$12,000 - $10,000 = $2,000 **(You Are Not Required to Pay This Amount)**
Total Amount We Pay for Procedure:	$10,000 (Our Allowed Amount) – $2,000 (Your Deductible) – $2,400 (Your Coinsurance) $5,600
Total Amount You Pay for Procedure:	$2,000 (Your Deductible) +$2,400 (Your Coinsurance) $4,400

By contrast, here is an example of what Your costs could be using an Out-of-Network Non-Participating Provider under a similar scenario detailed below.	
OUT-OF-NETWORK RULES	**OUT-OF-NETWORK AMOUNTS**
(A) Total amount billed by Non-Participating Provider for a procedure:	$12,000
(B) Our Out-of-Network Rate (ONR) for the procedure. This is the amount We pay all Non-Participating Providers for this procedure:	$10,000
Your Out-of-Network Deductible:	$4,000
(C) We subtract Your Deductible from (B):	$10,000 - $4,000 = $6,000
Your Out-of-Network Coinsurance:	40%
(D) We apply Your Coinsurance to (C):	40% of $6,000 = $2,400
Difference Between (A) and (B): **PLEASE NOTE:** Because We do not have a Contract with the Non-Participating Provider, You are required to pay the difference between the total billed amount and the ONR.	$12,000 - $10,000= $2,000 **(You Are Required to Pay This Amount in Excess of the ONR)**
Total Amount We Pay for Procedure:	$10,000 (Our Allowed Amount) – $4,000 (Your Deductible) – $2,400 (Your Coinsurance) $3,600
Total Amount You Pay for Procedure:	$4,000 (Your Deductible) + $2,400 (Your Coinsurance) + $2,000 (Amount in Excess of ONR) $8,400

1.8 Premium Payment and Grace Period. The monthly Premium is due on the first (1st) day of each month.

There is a one month day grace period for Premium payments. In other words, if the required Premium payment is not paid on or before the first (1st) day of the month (i.e., the due date), it may be paid during the grace period. This Contract will stay in force during the grace period. If the Premium payment is not received by the end of the grace period, Your Coverage under the Contract will be terminated effective at 11:59 p.m. on the last day of the grace period. If Your Coverage is terminated on the last day of the grace period, please be aware that You will be responsible for the Premium payment owed during the one month day grace period. You will be responsible for the cost of any health care services You receive after the grace period.

IF THE HEALTH INSURANCE MARKETPLACE HAS DETERMINED THAT YOU ARE A PERSON ELIGIBLE TO RECEIVE ADVANCE PAYMENT OF THE PREMIUM TAX CREDIT THE FOLLOWING APPLIES TO YOUR COVERAGE RATHER THAN THE ABOVE SECTION 1.8.

Premium Payment and Grace Period for Persons Receiving Advance Payment of the Premium Tax Credit. The monthly Premium is due on the first (1st) day of each month. There is a three (3) month grace period for Premium payments. In other words, if the required Premium payment is not paid on or before the first (1st) day of the month (i.e., the due date), it may

be paid during the grace period. During the first month of the grace period, We will continue to pay claims for Covered Services During the second and third months of the grace period, We will suspend payment of any claims until We receive the past due Premiums. If the payment is not received for all outstanding Premium by the end of the grace period, Your Coverage under the Contract will be terminated effective at 11:59 p.m. on the last day of the first month of the grace period. You will be responsible for the cost of any health care services You receive after the last day of the first month of the grace period.

1.9 Changes in Premium or Benefits.

Your rates that begin on Your Member Effective Date will not change until January first of each year. Upon renewal and in accordance with applicable law, We may increase or decrease the Premium and/or Covered Services for all Members Covered under an Individual Contract in the event that any state or federal laws or regulations require Us to Cover additional services, reduce Coinsurance or Deductibles, or otherwise expand Coverage in order to meet new minimum standards.

In the event of such change, You will receive a notice via U.S. mail at Your last known address sixty (60) days prior to the change.

Renewals occur the following year and are effective on the first (1st) day of January. Age band changes occur each year and are included in the annual renewal.

1.10 How to Contact the Health Plan.

Whenever You have a question or concern, please call Our Customer Service Department at the telephone number listed on Your Member ID card, or visit Our website at www.chctn.com. Our contact information is listed as follows.

For Customer Service Department and To Submit Claims	
Hours	Monday-Friday: [8:00 am to 6:00 pm EST]
Toll Free Telephone Number	**855-449-2889**
Address	[Coventry Health and Life Insurance Company P.O. Box 7813 London, KY 40742]
To Request a Review of Denied Claims or to Appeal a Denial of Authorization of Services	
Hours	Monday-Friday: [8:00 am to 6:00 pm EST]
Toll Free Telephone Number	**855-449-2889**
Address	**[**Coventry Health and Life Insurance Company 5350 Poplar Ave, Suite 390 Memphis, Tennessee 38119] Attn: Appeals Department
To Register a Complaint	
Hours	Monday-Friday: [8:00 am to 6:00 pm EST]
Toll Free Telephone Number	**855-449-2889**
Address	[Coventry Health and Life Insurance Company 5350 Poplar Ave, Suite 390 Memphis, Tennessee 38119] Attn: Quality Improvement Department

1.11 Verification of Benefits.

When We provide information about which health care services are Covered under Your Plan that information is referred to as verification of benefits. When You or Your Provider call Our Customer Service Department at **855-449-2889** during regular business hours to request verification of benefits, a Health Plan representative will be immediately available to provide assistance. If the health care services are verified as a Covered benefit, the Customer Service representative will advise whether Prior Authorization is required.

Please be aware that verification of benefits is not a guarantee of payment for services.

SECTION 2
ENROLLMENT, ELIGIBILITY, AND EFFECTIVE DATES

2.1 Eligibility.

2.1.1 Subscriber Eligibility.

To be eligible to be enrolled as a Subscriber, You must apply to the Health Insurance Marketplace. The Health Insurance Marketplace will notify Us if You are a Qualified Individual.

2.1.2 Dependent Eligibility.

To be eligible to be enrolled as a Dependent, an individual must be a Qualified Individual.

2.2 Persons Not Eligible to Enroll.

Any person that the Health Insurance Marketplace determines is not a Qualified Individual.

2.3 Enrollment and Effective Dates.

Your enrollment will be effective as of the date provided to us by the Health Insurance Marketplace.

2.4 Notification of Change in Status.

You must notify Us or the Exchange, in writing, of any changes in Your status or the status of any Dependent within thirty-one (31) days after the date of the status change. This notification must be submitted to Us in writing. Events that qualify as a change in status include, but are not limited to, changes in address, divorce, marriage, death, dependency status, incarceration, loss of legal residency in the United States, Medicare eligibility, or Coverage by another insurance policy. Coventry requires notice of Medicare eligibility or Coverage by another payer for purposes of coordinating benefits. We should be notified within a reasonable time of the death of any Member. For more information, call Customer Service at (866) 364-5663.

2.5 If You Become Eligible for Medicare While Covered Under Carelink from Coventry®.

Under the terms of this Contract, Medicare will pay primary, to the extent stated in federal law. In the event that You are eligible for Medicare Parts A, B, and/or D, We will base Our payment upon the benefits covered by the applicable Medicare Part, regardless of whether or not You are actually enrolled. As long as You continue to pay Premium to Us, You will remain enrolled in Your Carelink from Coventry® policy, subject to the reduced benefits described above. Please direct any questions regarding Medicare eligibility and enrollment to Your local Social Security Administration office.

SECTION 3
TERMINATION OF COVERAGE

3.1 Termination.

A. Termination by Subscriber.

The Subscriber may terminate Coverage for himself/herself and any enrolled Dependents under the Contract for any reason by providing fourteen (14) days advance written notice to the Health Insurance Marketplace. . For notices received on the 1st through 15th day of the month, termination will take effect on the first day of the month in which the notice was received. For notices received on the 16th through 31st day of the month, termination will take effect on the first day of the month following the month in which the notice was received, unless the Health Plan agrees to an earlier termination. The notice of termination should be sent to:

[insert Health Insurance Marketplace]

B. Termination by Us.

1. Non-Payment of Premium.

a. Non-Payment of Premiums.

In the event that We do not receive payment of all outstanding Premium by the end of the one month grace period, Your Coverage under the Contract will be terminated at 11:59 p.m. on the last day of the grace period. If Your Coverage is terminated for non-payment of the Premium, You will be responsible for the cost of any health care services You receive after the grace period.

IF THE HEALTH INSURANCE MARKETPLACE HAS DETERMINED THAT YOU ARE A PERSON ELIGIBLE TO RECEIVE ADVANCE PAYMENT OF THE PREMIUM TAX CREDIT THE FOLLOWING APPLIES TO TERMINATION OF YOUR COVERAGE RATHER THAN THE ABOVE SECTION B.

In the event that We do not receive payment of all outstanding Premium by the end of the three (3) month grace period, Your Coverage under the Contract will be terminated at 11:59 p.m. on the last day of the first month of the grace period. If Your Coverage is terminated for non-payment of the Premium, You will be responsible for the cost of any health care services You receive after the last day of the first month of the grace period.

2. Reinstatement After Termination for Non-Payment of Premium.

Reinstatement of Your Coverage will be as permitted by and in accordance with the Health Insurance Marketplace.

3. Fraud.

If You or Your enrolled Dependents participate in fraudulent or criminal behavior in connection with enrollment or Coverage under the Contract, Coverage for You and Your enrolled Dependents shall end at 11:59 p.m. upon the date set forth in Our notice of termination to the Subscriber. Examples of fraud include, but are not limited to the following:

a. Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts, including using Your Member ID card to obtain goods or services that are not prescribed or ordered for You or to which You are otherwise not legally entitled. In this instance, Coverage for the Subscriber and all Dependents will be terminated.

b. Knowingly allowing any other person to use Your Member ID card to obtain services. If a Dependent allows any other person to use his/her Member ID card to obtain services, the Coverage of the Dependent that allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his/her Member ID card to obtain services, the Coverage of the Subscriber and his/her Dependents will be terminated.

c. Intentionally misrepresenting or giving false information in Your application for Coverage to the Health Insurance Marketplace that is material to Our acceptance of Your enrollment.

d. Engaging in fraudulent activity with respect to obtaining health services, including but not limited to, using and obtaining medications in a manner that contradicts Your Prescription or standard prescribing practices.

4. Dependent Eligibility Ends Due to Attainment of Limiting Age, Unless Disabled.

When the Dependent attains the age of twenty-six (26), unless disabled, the Dependent shall no longer meet the eligibility requirements for Dependents, as set forth in this Contract. The Dependent is entitled to apply to the Health Insurance Marketplace for Coverage if the Dependent is a Qualified Individuall.

The Dependent shall be considered Totally Disabled if the Dependent is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

5. Dependent Eligibility Ends Due to Subscriber Termination.

If a Subscriber requests to terminate the Contract and the termination results in only children under the age of nineteen (19) remaining on the Contract, the Dependent(s) Coverage under the Contract will also terminate on the same termination date as the Subscriber. The Dependent(s) are entitled to apply to the Health Insurance Marketplace for Coverage if the Dependent is a Qualified Individual.

6. Termination of Dependent Spouse Coverage Due to Death or Divorce of Subscriber Spouse.

If the Dependent spouse dies or enters a valid divorce decree, Coverage as a Dependent spouse will be terminated. The spouse is entitled to apply to the Health Insurance Marketplace for Coverage if the spouse is a Qualified Individual.

7. Termination of Coverage in the Market.

a. Termination of Plan Type.

If We cease to offer the Coventry individual policy in the individual market, We will provide to all Members Covered by such policy at least sixty (60) days notice prior to the discontinuance of the policy. In such an instance, We will:

- Offer such Members the option to purchase all other individual policies currently being offered to or renewed by individuals for which the Member is eligible; and

- Act uniformly without regard to the claims experience or any health status related factor of Members or individuals eligible to be Members.

b. Ceasing To Do Business in Individual Market.

If We discontinue offering all Plans in the individual market, We will provide to all Members and the state Commissioner of Insurance at least one hundred eighty (180) days notice prior to the discontinuance of all policies in the individual market. In such an instance, We will:

- Not issue Coverage in the individual market for five (5) years beginning with the date of the last policy or Contract in that market not renewed.

- Act uniformly without regard to the claims experience or any health status related factor of Members or individuals eligible to be Members.

Upon such termination, You may be eligible for a special enrollment period. Contact the Health Insurance Marketplace.

8. Eligibility Requirements.

Your Coverage shall continue as long as You continue to meet the eligibility requirements as required by the state and federal laws governing the Health Insurance Marketplace and shall cease if You no longer meet eligibility requirements.

9. Moving out of the Service Area.

At least sixty (60) days notice of termination of Your Coverage will be provided by U.S. mail if You no longer live in the Service Area. Upon such termination, You may be eligible to apply to the Health Insurance Marketplace for other available Health Insurance Marketplace Plans.

10. Incarceration.

Upon such termination, You may be eligible for a special enrollment period. Contact the Health Insurance Marketplace. For purposes of termination of eligibility, “incarceration” means incarceration other than incarceration pending the disposition of charges.

3.2 Renewal.

Renewals occur on the first (1st) day of January, each year. Your Plan is renewable as long as Premiums are paid, and You and Your Dependents continue to meet eligibility requirements and remain in the Coventry Health and Life Insurance Company Service Area. We will not change Your Premium because of claims filed or due to a change in Your health since becoming a Member. Renewal Premiums are based on Your original Premium, age, gender, area of residence, and the type of Plan You have.

3.3 Effect of Termination.

If Your Coverage under the Contract terminates, all rights to receive Covered Services shall cease as of 11:59 p.m. on the date of termination.

Member ID cards are Our property and, upon request, shall be returned to Us within thirty-one (31) days of the termination of Your Coverage. Member ID cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.

Your Coverage shall not be terminated on the basis of Your health status or the exercise of Your rights under Our complaint procedures.

Termination will be without prejudice to any claim originating prior to the effective date of termination.

3.4 Certificate of Creditable Coverage.

At the time Coverage terminates, You are entitled to receive a certificate verifying the type of Coverage, the date of any waiting periods, and the date any creditable Coverage began and ended.

A certificate of creditable Coverage under this Contract will be issued:

A. When a Subscriber or Dependent ceases to be Covered under this Contract for any reason, or

B. When requested by a Subscriber or Dependent within twenty-four (24) months of the termination of Coverage.

SECTION 4
CLAIMS FOR REIMBURSEMENT OF SERVICES RENDERED BY NON-PARTICIPATING PROVIDERS

4.1 Notice of Claim and Timely Submission of Claim.

Participating Providers are responsible for submitting claims directly to Us for Covered Services provided to Members. However, when You receive Covered Services from a Non-Participating Provider, You must provide Us written notice of the claim within twelve (12) months of the date of service. Except in the absence of the Member's legal capacity, claims or bills will not be accepted from Members later than one (1) year after the date of service. Such services must have been provided in accordance with Our Utilization Management Program and Prior Authorization policies and procedures. Failure to furnish such documentation within the specified period shall invalidate any such claim.

Upon notice of a claim, CHL shall furnish claim forms to the claimant for filing for the proof of loss. If We do not supply claim forms to You within ten (10) working days after receipt of Your notice, You will be considered to have complied with these requirements. Claims for Covered Services rendered by Non-Participating Providers should be sent to Our Claims Department at the following address.

Carelink from Coventry Claims Department
[P.O. Box 7813
London, KY 40742]

Notice given by You or on Your behalf to Us at the address above or to any Authorized agent of Ours with sufficient information to identify You shall be deemed notice to Us.

4.2 Timely Payment of Claims.

Upon timely receipt of a claim for a Covered Service, We will promptly make payment to the person or institution providing the Covered Service, or at Our discretion, We may make payment directly to the Subscriber. We will pay a Non-Participating Provider the Out of Network, however, the Non-Participating Provider may balance bill You for charges over the amount We have Contracted with the Participating Provider.

4.3 Legal Action.

No action at law or equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished to CHL as required above. No action shall be brought after the expiration of two (2) years after the time written proof is required to be furnished.

SECTION 5
COVERED SERVICES

5.1 Schedule of Covered Services.

Under this PP0 Plan, inpatient, outpatient, and other Covered Services are available through both In-Network (Participating) Providers and Out-of-Network (Non-Participating) Providers. Benefits under this Plan are subject to Our Utilization Management Program. Please be aware that Coverage may be denied if the Covered Services You receive are not compliant with the Utilization Management Program. See Section 1.3 for more information on Our Utilization Management Program.

Keep in mind that using a Participating Provider (Your In-Network benefits) will usually cost You less than using a Non-Participating Provider (Your Out-of-Network benefits). This is because Participating Providers are Contracted with Us to provide health care services to Members for a lower fee, whereas Non-Participating Providers are not Contracted with Us. Please see Section 1 for more information on how Your In-Network and Out-of-Network benefits work.

Please note that the Health Plan Covers only those health care services and supplies that are:

(1) deemed Medically Necessary,

(2) Authorized, if Authorization is required,

(3) listed in as Covered Service in the Contract and not Excluded under the Contract, and

(4) incurred while the Member is eligible for Coverage under the Contract

See Section 1.3. Prior Authorization is required for some services. It is advised that either You or Your Provider call Customer Service for clarification if there are any concerns. Benefits may be subject to other limitations, as outlined in this document or affiliated schedules and riders.

COVERED SERVICES

Health Plan Covers only those Covered Services and supplies that are (1) deemed Medically Necessary, (2) Authorized, if Authorization is required, (3) listed below and not excluded in the Exclusions and Limitations set forth in this Schedule, and (4) incurred while the Member is eligible for Coverage under the Contract.

Those health care services and supplies that are Covered Services under the Contract are listed below. This list is subject to the Exclusions and limitations set forth in this Schedule. In the event of any conflict between the list of Exclusions and limitations set forth in this Schedule and the Covered Services list below, the list of Exclusions and limitations shall govern.

SCHEDULE OF COVERED SERVICES THIS DETAILS THE COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHL TO BE MEDICALLY NECESSARY AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6	
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
Allergy	Covered Service. Testing, diagnosis, treatment, allergy serum, and the administration of injections.
Ambulance	Covered Service. Ambulance transport is a Covered Service when deemed Medically Necessary.
Bone Density Testing	**See "Preventive Services" in this Section.**
Breast Reconstruction	Covered Service when consistent with the federal Women's Health and Cancer Rights Act of 1998. If You have a mastectomy and elect Reconstructive Surgery in connection with the mastectomy, Coverage will be provided for: 1. Reconstruction of the breast on which the mastectomy was performed; 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3. Prostheses and physical complications of mastectomy, including lymphedema. Coverage will be provided in a manner determined in consultation between You and Your attending Physician. Reconstructive breast surgery following a mastectomy will be covered regardless of the lapse of time since the mastectomy. **Post-Mastectomy Care** Following a Medically Necessary mastectomy, the decision whether to discharge the Member is made by the attending Physician in accordance with currently accepted medical criteria.
Cardiac Rehabilitation Therapy **(Outpatient)**	Covered Service.
Chemotherapy for Cancer	Covered Service.
Child Wellness Care	**See "Preventive Services" in this Section.**

SCHEDULE OF COVERED SERVICES THIS DETAILS THE COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHL TO BE MEDICALLY NECESSARY AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6	
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
Cleft Palate	Medically Necessary and appropriate therapeutic and rehabilitative services performed in a Physician's office, outpatient Facility or Home Health setting and intended to restore or improve bodily function lost as the result of cleft palate. Outpatient, Home Health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from cleft palate. The services must be performed by, or under the direct supervision of a licensed therapist, upon written Authorization of the treating Physician. Speech therapy is Covered only for disorders of articulation and swallowing, resulting from cleft palate."
Clinical Trials	Covered Service. Coverage is provided for routine Patient Costs associated with a cancer clinical trial for which a Member voluntarily participates. Coverage of routine Patient Costs associated with a randomized and controlled Phase III and Phase IV clinical trial for the treatment of cancer will be covered if **all** of the following conditions are satisfied: 1. A written protocol is provided and includes selection criteria, objectives for the trial, expected outcomes, specific directions for administering the therapy and monitoring patients, a definition of quantitative measures for determining treatment response, and methods for documenting and treating adverse reactions; 2. The trial must be designed with therapeutic intent and not exclusively test toxicity or disease pathophysiology; 3. The trial must be in compliance with Federal Regulations relating to the protection of human subjects (e.g., National Institutes of Health (NIH), Food and Drug Administration (FDA)); 4. The trial must have Institutional Review Board (IRB) approval; 5. The treatment is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following: a. One of the National Institutes of Health. b. A National Institutes of Health cooperative group or center. c. The United States Food and Drug Administration in the form of an Investigational new drug application. d. The United States Department of Defense. e. The United States Department of Veterans' Affairs. f. A qualified research entity that meets the criteria established by the National Institutes of Health for grant eligibility. g. A panel of qualified recognized experts in clinical research within academic health institutions in this state; 6. The trial must be conducted according to appropriate standards of scientific integrity; 7. The trial cannot duplicate existing studies;

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
	8. The personnel providing the treatment or conducting the study: a. Are providing the treatment or conducting the study within their scope of practice, experience and training, and are capable of providing the treatment because of their experience, training, and volume of patients treated to maintain expertise. b. Agree to accept reimbursement as payment in full from the accountable Health Plan at the rates that are established by the Plan and that are not more than the level of reimbursement applicable to other similar services provided by health care Providers with the Plan's Provider Network; 9. There is no clearly superior, non-Investigational treatment alternative; and 10. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as any non-Investigational alternative.
Colorectal Cancer Screenings	**See "Preventive Services" in this Section.**
Dental-Related Anesthesia and Hospital or Ambulatory Facility Charges	Covered Service. Dental-related anesthesia and Hospital or Facility charges for dental services performed in a Hospital or ambulatory surgical Facility in connection with dental procedures for: 1. Children seven (7) years of age or younger; 2. Persons with serious mental or physical conditions; 3. Persons with significant behavioral problems; where the Provider treating the patient certifies that because of the patient's age, condition, or problem, Hospitalization or general anesthesia is required in order to safely and effectively perform the dental procedure(s).
Diabetic Treatment, Supplies and Equipment	Covered Service. Coverage is provided for Medically Necessary equipment, supplies, one dilated eye exam/year, pharmacologic agents, and outpatient self-management training and education, including medical nutrition therapy. Medically Necessary equipment, supplies, and pharmacological agents include: Glucometers, test strips and related accessories for glucose monitors, insulin, injection aids and supplies, injection devices, insulin cartridges, insulin pumps, insulin infusion devices, oral agents for diabetes maintenance, and other equipment, supplies and drugs determined to be Medically Necessary and consistent with the standards of the American Diabetes Association. Routine foot care such as removal or reduction of corns and calluses and clipping of the nails is covered for diabetics only. The following are Covered under Your Prescription Drug benefits: 1. Oral medications; 2. Test strips; 3. Lancets;

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
	4. Syringes; and 5. Insulin.
Dialysis	Covered Service. Hemodialysis and peritoneal services provided by outpatient or inpatient facilities or vendors. Home hemodialysis, equipment, supplies, and maintenance are covered for homebound Members as certified by their attending Physician.
Durable Medical Equipment (DME)	Medically Necessary and appropriate medical equipment or items that: 1. in the absence of illness or injury, are of no medical or other value to You; 2. can withstand repeated use in an ambulatory or home setting; 3. require the prescription of a Physician for purchase; 4. are approved by the FDA for the illness or injury for which it is prescribed; and 5. are not solely for Your convenience. Covered Services a. Rental of Durable Medical Equipment - Maximum allowable rental charge not to exceed the total Maximum Allowable Charge for purchase. If You rent the same type of equipment from multiple DME Providers, and the total rental charges from the multiple Providers exceed the purchase price of a single piece of equipment, You will be responsible for amounts in excess of the Maximum Allowable Charge for purchase. b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment. c. Supplies and accessories necessary for the effective functioning of Covered Durable Medical Equipment. d. The replacement of items needed as the result of normal wear and tear, defects or obsolescence and aging. Insulin pump replacement is Covered only for pumps older than 48 months and only if the pump cannot be repaired.
Emergency Services	Covered Service for those health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, which would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his/her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in: 1. Placing the Member's health in serious jeopardy; 2. Placing the health of a pregnant Member and the health of her unborn child in serious jeopardy; 3. Serious impairment to bodily function; or 4. Serious dysfunction of any bodily organ or part. Payment of services shall be based on retrospective review of Your presenting history, symptoms, and Hospital records.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
Eyeglasses and Corrective Lenses	Covered Service for the first pair of eyeglasses with lenses or corrective lenses following cataract surgery. Standard contact lenses will be Covered and premium lenses will be Excluded.
Family Planning and Reproductive Services	Medically Necessary and appropriate family planning services and those services to diagnose and treat diseases that may adversely affect fertility. 1. Covered Services a. Benefits for: (1) family planning; (2) history; (3) physical examination; (4) diagnostic testing; and (5) genetic testing. b. Sterilization procedures. c. Services or supplies for the evaluation of infertility. d. Medically Necessary and appropriate termination of a pregnancy. e. Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting, insertion and removal.
Genetic Counseling and Testing	Covered Service. 1. Genetic counseling and studies that are needed for diagnosis and treatment of genetic defects when the result of the genetic test will directly impact treatment for the Member; or 2. There is a history of an inheritable genetic disease and the published Peer-Reviewed Medical Literature documents that its use will improve outcomes; or 3. There is a substantial familial risk for being a carrier for a particular detectable mutation that is recognized to be attributable to a specific genetic disorder.
Habilitative and Rehabilitation Services	Covered Service. Habilitative Services are health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Hearing Aid	Hearing aids are Covered for members under the age of 18, up to **one hearing aid per ear every 3 years**

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
Home Health Care	Covered Service. Covered when all of the following requirements are met: 1. The service is ordered by a Physician; 2. Services required are of a type that can only be performed by a Physician, licensed nurse, physical therapist, speech therapist, or occupational therapist; 3. The services are an alternative to Hospitalization; 4. Part-time, intermittent services are required; 5. A treatment Plan has been established and periodically reviewed by the ordering Physician; 6. The services are Authorized by the Health Plan; 7. The agency rendering services is Medicare certified and licensed by the State of location; and 8. The Member is home bound as certified by his/her attending Physician.
Hospice Services	Covered Service if **all** of the following conditions are met: 1. Your Provider certifies that You have a life expectancy of six (6) months or less; 2. Before the services are provided, Your Provider prepares a written treatment plan Authorizing the services; and 3. A state licensed Hospice within the Service Area is providing Medically Necessary Hospice Services.
Inherited Metabolic Disorder-PKU	Treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Physician
Inpatient Hospital Care	Covered Service. Coverage is dependent on the establishment of Medical Necessity for the care. Semi-private accommodations are covered. Private, if determined to be Medically Necessary, are Covered. Maternity and delivery services (including routine nursery care and Complications of Pregnancy). If the Hospital or Physician provides services to the baby and submits a claim in the baby's name, benefits may be Covered for the baby and mother as separate Members, requiring payment of applicable Member Copayments and/or Deductibles.
Laboratory Services	Covered Service.
Mammogram	**See "Preventive Services" in this Section.**
Maternity	1. Surgical and Medical Services. a. Initial office visit and visits during the term of the pregnancy. b. Diagnostic Services.

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	c. Delivery, including necessary pre-natal and post-natal care. d. Medically Necessary abortions required to save the life of the mother. 2. Hospital services required in connection with pregnancy and Medically Necessary abortions as described above. The Hospital (nursery) charge for well-baby care is included in the mother's Benefits for the Covered portion of her Admission for Pregnancy Care.
Medical Supplies, Disposable	Those Medically Necessary and appropriate expendable and disposable supplies for the treatment of disease or injury. 1. Covered Services a. Supplies for the treatment of disease or injury used in a Physician's office, outpatient Facility or inpatient Facility b. Supplies for treatment of disease or injury that are prescribed by a Practitioner and cannot be obtained without a Physician's prescription. 2. Exclusions a. Supplies that can be obtained without a prescription (except for diabetic supplies). Examples include but are not limited to: (1) adhesive bandages; (2) dressing material for home use; (3) antiseptics, (4) medicated creams and ointments; (5) cotton swabs; and (6) eyewash.
Mental Health and Substance Abuse	Coverage is provided for Medically Necessary treatment of Mental Health Conditions and Chemical Dependency Services through partial or full day outpatient programs or nonresidential inpatient treatment. As an alternative to Hospital inpatient days, if less costly residential treatment, partial Hospitalization, or crisis respite care for the patient is appropriate, the Plan shall provide for this care at the rate of two (2) alternate care days to one (1) day of inpatient Hospital treatment. See Your Schedule of Benefits for information. CHL Contracts with a Mental Health and Substance Abuse Designee to coordinate, determine Medical Necessity, and Prior Authorize the diagnosis and treatment of all Mental Health Conditions.
Newborn Care	The Covered Services for eligible newborn children shall consist of Coverage for Injury or Illness, including Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of the newborn to and from the nearest Facility that is appropriately staffed and equipped to treat the newborn's condition. Coverage is provided for all newborns to be tested or screened for phenylketonuria (PKU), hypothyroidism, galactosemia, and such other common metabolic or genetic diseases that would result in mental retardation or physical dysfunction. Coverage is also provided for newborn hearing screening examinations, any necessary rescreening, audiological assessment and any requisite follow-up.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
Non-Emergency Care When Travelling Outside the U.S.	When You need to locate a Hospital or Physician, You can call the Customer Service Center to help you locate a Physician. You will only be responsible for the Plan's usual Out-Of-Pocket expense for Out-Of-Network benefits (i.e., non-Covered expenses, Deductible, Copayment and/or Coinsurance). Your out-of-pocket expenses may be significantly higher than if You had seen an In-Network Provider. In an Emergency, You should go to the nearest Hospital and call the Customer Service Center if You are admitted. You may have to pay the Hospital directly and then file a claim for reimbursement.
Occupational Therapy	**Refer to Short-Term Therapies.**
Oral Surgery Services	Covered Service. Removal of tumors and cysts of the jaws, lips, cheeks, tongue, roof and floor of the mouth, and removal of bony growths of the jaw, soft, and hard palate. Covered Service, if as a result of trauma, You must seek treatment within twenty-four (24) hours of the accidental injury, unless incapacitated at time of trauma. Coverage is limited to the functional restoration of structures and treatment resulting in fracture of jaw or laceration of mouth, tongue, or gums.
Oral Surgery Services for Treatment of Temporomandibular Joint (TMJ)	Covered Service. Surgical and non-surgical medical treatment of TMJ dysfunction is covered if a Physician administers the treatment. Treatment for TMJ may include surgery for the correction of the bone or joint structure of the maxilla or mandible, such that the normal character and essential function of such bone structure is restored. Non-surgical treatment may include history and examination; diagnostic radiographs; splint therapy; and diagnostic or therapeutic masticatory muscle and temporomandibular joint injections.
Orthotics	Covered Service, unless specifically excluded. Orthotics are accessories that provide stability, external control, correction, and support for a body part.
Outpatient Services	Covered Service. Diagnostic or therapeutic services that are: 1. Covered Services; and 2. Performed outside the Physician's office.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
Outpatient / Ambulatory Surgery	Covered Service. Covered surgery not performed in a Physician's office or inpatient setting.
Ovarian Cancer Screenings	**See "Preventive Services" in this Section.**
Pap Smear	**See "Preventive Services" in this Section.**
Pediatric Vision	[Covered Service. Coverage includes yearly exam, frames, and lenses. See Your Schedule of Benefits for Coverage details. Standard contact lenses will be Covered and premium lenses will be Excluded. Covered Service for Members that are under age 19. For a description of the pediatric vision Covered Services and limitations, see Your Schedule of Benefits.
Physical Therapy	**Refer to Short-Term Therapies**
Prescription Drugs	Covered Service. Subject to the applicable limitations, Exclusions, Copayments, Coinsurance, and Deductibles, outpatient Prescription Drugs will be Covered when: • ordered by a Prescribing Provider for use by the Member, if the Prescribing Provider is lawfully able to prescribe Prescription Drugs, and • not limited or excluded elsewhere in this Contract; and • filled at a Participating Pharmacy [or Specialty Pharmacy], including a Mail Order Pharmacy, designated by Us (except for Emergency Services out of the Service Area); and • Prior Authorized, if applicable. Certain **Prescription Drugs** which are prescribed for the treatment of long-term or chronic conditions are considered to be Maintenance Drugs under the terms of this Contract. If You are prescribed a Maintenance Drug, You may obtain the first prescription fill for a 31-day supply and one additional Refill at a Participating Pharmacy that is a retail pharmacy. Before receiving the third fill of the Maintenance Drug at the Participating Pharmacy that is a retail pharmacy, You must notify Us of whether you want to use Your Mail Order Pharmacy benefit or continue to obtain Your Maintenance Drug at Participating Pharmacy that is a retail pharmacy. If You fail to inform Us of Your choice, then the third prescription fill (and any subsequent Refill of the Maintenance Drug) at a retail pharmacy will not be Covered. You may contact Us at any time to let Us know that You intent to use a Participating Pharmacy that is a retail pharmacy for future fills of Your Maintenance Drugs. In no event shall a Member receive coverage under this Contract for **Prescription Drugs** filled at a Participating Pharmacy unless he/she presents his/her ID card to the Participating Pharmacy. Prescriptions filled at a Participating Pharmacy must be submitted through the on-line claims adjudication process in order to be Covered. Members presently taking a prescription drug shall be notified at least thirty days prior to any deletions to the Formulary. Notifications will not be provided for generic substitutions.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
	The Member shall pay the Participating Pharmacy: • An amount up to the Prescription Drug Deductible, as applicable, and as identified in the Schedule of Benefits; • One hundred percent (100%) of the cost of a Prescription Drug dispensed when the Member fails to show his/her identification card at the Participating Pharmacy; • One hundred percent (100%) of the cost of a Prescription Drug or Specialty Drug dispensed at quantities above the approved amount; • One hundred percent (100%) of the cost of a Prescription Drug or Specialty Drug that is Excluded from Coverage under Your Prescription Drug benefit; • Any applicable Copayments and/or Coinsurance. Your annual Deductible for **Prescription Drugs** is as set forth in the Schedule of Benefits. The annual Deductible must be satisfied each calendar year before a Member may receive Coverage for **Prescription Drugs.** Total Member payments for a Covered Drug shall not exceed the retail price of the Prescription Drug. Payment for Covered Drugs is limited to the Contracted amount the Health Plan would normally pay, less the Member's applicable Copayment, Coinsurance and/or Deductible. The Copayment or Coinsurance for each Prescription Order or Refill of one Prescribing Unit of a Formulary generic or Formulary brand name other than a Specialty Drug is as set forth in the Schedule of Benefits. **Specialty Drugs** **Specialty Drugs** are Covered under this Contract in the amounts described below when they are: • Ordered by a prescribing Provider for use by a Member if the prescribing provider is lawfully able to prescribe such drugs, and • Not limited or excluded elsewhere in this Contract; and • Obtained from a Plan Approved Specialty Pharmacy; and • Prior Authorized; [and • Subject to quantity limits • Limited to no more than a 30 day supply per fill • Listed on Our Formulary. **Specialty Drugs** should be filled or Refilled through one of the Participating Specialty Pharmacies designated by the Health Plan in order to receive the highest level of Coverage. If You fill or Refill Your order for **Specialty Drugs** through a Non-Participating

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
	Specialty Pharmacy or Participating or Non-Participating Pharmacy, we will not provider any Coverage for the Prescription Drug. You shall pay the following to a Specialty Pharmacy, as applicable: • Prescription Drug Deductibles; and • Any applicable Coinsurance],Copayment. The applicable Coinsurance, Copayment You must pay for each Prescribing Unit of a **Specialty Drugs** is as set forth in the Schedule of Benefits. **Prescribing Units.** A **Prescribing Unit** is the amount of the Prescription Drug or Specialty Drug that will be dispensed for a single Copayment [or for which any minimum or maximum Coinsurance amount will be calculated]. For any drug, if two (2) or more different strengths, method of drug delivery, formulation or drug name are prescribed for use during the same time period, each will constitute a separate Prescribing Unit and Copayment/Coinsurance. We also reserve the right to cover the least number of tablets and/or capsules in order to obtain the daily dose needed as long as it is within the Plan's quantity limits and/or Plan's approved dose, each will constitute a separate **Prescribing Unit** and Copayment/Coinsurance. The **Prescribing Unit** of a Prescription Drug and/or Specialty Drugs dispensed by a Participating Pharmacy pursuant to one (1) Prescription Order or Refill shall be limited to the lesser of: • The quantity prescribed in the Prescription Order or Refill; or • A 31day supply as defined by Us; or • The quantity limit set by Us for a specific drug; or • The amount necessary to provide a [30-31] day supply according to the maximum dosage approved by the Food and Drug Administration for the indication for which the drug was prescribed; or • Depending on the form and packaging of the product, the following: (i) Tablets/capsules/suppositories – 100; or (ii) Oral liquids – 480 cc; or (iii) Commercially prepackaged items (such as but not limited to, inhalers, topicals, and vials) – 1 unit (i.e., box, tube or inhaler); [or (iv) Specialty Drugs– a sufficient amount to provide the prescribed amount for four (4) weeks. Any Covered Drug that has a duration of action extending beyond one (1) month shall require the number of Copayments per **Prescribing Unit** that is equal to the anticipated duration of the medication. For example, Depo-Provera is effective for

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
	three (3) months and would require three (3) Copayments. The **Prescribing Unit** for insulin and diabetic supplies (insulin syringes, with or without needles, needles, blood and urine glucose test strips, ketone test strips and tabs) shall be limited to the lesser of: • The quantity prescribed in the Prescription Order or Refill; or • A 31day supply as defined by the Health Plan; or • The quantity limit set by Us for a specific drug; or • The amount necessary to provide a [30-31] day supply according to the maximum dosage approved by the Food and Drug Administration for the indication for which the drug was prescribed; or • One (1) vial of insulin; or • One (1) commercially prepackaged set of syringes, test strips, tablets, capsules, lancets or other supply. The quantity of Maintenance Drugs obtained through a Mail Order shall be limited to the lesser of: • The quantity prescribed in the Prescription Order or Refill; or • A 90-day supply as defined by Us. Member shall pay: (a) three (3) Copayments per 90-day supply Prescription Order or Refill; or (b) for commercially prepackaged drugs, such as topicals, inhalers and vials, one (1) Copayment for each package or unit.
Preventive Services	Covered Service. Medically Necessary preventive services as defined under PPACA, including: • Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force; • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; • With respect to infants, children and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and • With respect to women, such additional preventive care and screenings not described in bullet point one as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**
Prosthetics	Covered Service. Prosthetic devices, which replace an external body part and are utilized for a specific patient and not otherwise excluded, are Covered when Medically Necessary. Testicular Prostheses is considered Medically Necessary for replacement of congenitally absent testes, or testes lost due to disease, injury, or surgery.
Pulmonary Rehabilitation Therapy (Outpatient)	Covered Service.
Radiation Therapy	Covered Service.
Radiology	Covered Service.
Reconstructive Surgery	Covered Service for: 1. Surgery and associated services to repair disfigurement resulting from an injury. 2. Surgery to correct significant defects from congenital causes (except where specifically excluded. 3. Services associated with Reconstructive Surgery necessary to correct disfigurement incidental to a previous surgery. 4. Services associated with a surgery that substantially improves functioning of any malformed body part, unless specifically Excluded elsewhere in this Contract.
Short-Term Therapies: ~ **Occupational Therapy** ~ **Physical Therapy** ~ **Speech Therapy**	Covered Service. Please refer to Your Schedule of Benefits for possible limitations.
Skilled Nursing Facility	Covered Service when deemed Medically Necessary by the Health Plan in lieu of Hospitalization. Please refer to Your Schedule of Benefits for possible limitations.
Spinal Manipulation	Covered Service
Transplants	Covered Service, as follows: 1. Services related to Medically Necessary organ transplants if the Covered transplant Services are performed at a Coventry Transplant Network Facility. 2. Donor screening tests when the testing is performed at a Coventry Transplant Network Facility. 3. If the donor is not covered by any other source, the cost of any care, including complications, arising from an organ donation by a non-covered individual when the recipient is a Covered Member will be covered for the duration of the Contract of the Covered Member. 4. Travel expenses for Members and living donors are covered according to Our transplant travel benefit, as long as CHL is the primary insurer and a Coventry

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	Transplant Network Facility is used. 5. In order to be Covered, Transplants must be rendered by a Coventry Transplant Network Facility. **Transplants that are provided at a non-Coventry Transplant Network Facility, even if the non-Coventry Transplant Network Facility is a Participating Provider, are *not* covered.**
Urgent Care	Covered Service. Covered Urgent Care for an unexpected illness or injury that does not qualify as an Emergency but requires prompt medical attention. Urgent Care Services are covered whether provided by Participating or Non-Participating Providers.

SECTION 6
EXCLUSIONS AND LIMITATIONS

The Health Plan does not cover the items listed below. In the event of any conflict between the list of Exclusions and limitations set forth below and the Covered Services list above, the list of Exclusions and limitations shall govern.

6.1 The Health Plan does not cover the following items:

1. [Any service or supply rendered by a Specialist and for which a PCP referral is required, except that Emergency Services, obstetrical and gynecological care from an In-Network Provider and mental health and substance abuse services from an In-Network Provider that are otherwise Covered Services shall be covered in accordance with the terms and conditions set forth in the Contract regardless of whether a PCP referral is obtained];

2. Any service or supply that is not Medically Necessary;

3. Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-covered service;

4. Any service or supply for which You have no financial liability or that was provided at no charge;

5. Non-Emergency Services provided outside the Service Area, including elective care, obstetrical services [after 37 weeks of pregnancy], follow-up care of an illness or injury, or care required as a result of circumstances that could have been reasonably foreseen by You before leaving the Service Area.

6. Procedures and treatments that We determine, in Our sole and absolute discretion to be Experimental or Investigational.

7. Services and or supplies rendered as a result of injuries sustained during the commission of an illegal act;

8. Court-ordered services or services that are a condition of probation or parole;

9. Any service or supply for which Health Plan has not received or for which Health Plan has not received from a Health Insurance Marketplace, confirmation of Member's eligibility; and

10. Any service for which a Prior Authorization is required and is not obtained.

11. Treatment, services, and supplies for an Injury are not Covered when a contributing cause was Your illegal or excessive use of alcohol, including driving while under the influence of alcohol. A police officer's or treating Provider's determination that You were functioning under the influence of illegal or excessive use of alcohol when the Injury was sustained will be sufficient evidence for this Exclusion to apply.

12. Treatment, services, and supplies for an Injury are not Covered when a contributing cause was Your voluntary taking of or being under the influence of an intoxicant or narcotic that was not taken or administered on the advice of a Physician, including driving while under the influence of such intoxicant or narcotic. A police officer's or treating Provider's determination that You were functioning under the influence of such intoxicant or narcotic when the Injury was sustained will be sufficient evidence for this Exclusion to apply.

13. Treatment, services, and supplies required to treat an Injury or illness that was directly or indirectly caused by an intentional or negligent action by You are not Covered, unless such Injury or illness is the direct result of an act of domestic violence or a medical condition.

14. Any medical service that is directly or indirectly the result of receiving a Non-Covered Service, procedure, Prescription Drug, medicine, equipment, or supply, including any associated complications, is Excluded from Coverage.

15. We Exclude from Coverage any charges that are in excess of Your Benefit Maximum, as described in Your Schedule of Benefits.

6.2 Specifically Excluded Services include but are not limited to (this is not an exhaustive list):

1. Abortion services and supplies, except in the cases where (i) a Member suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a Physician, place the Member in danger of death unless an abortion is performed or (ii) the pregnancy is the result of an act of rape or incest.

2. Acupuncture & Acupressure - Acupuncture and acupressure services.

3. Alopecia - Alopecia treatment, including the treatment of age-related hair loss.

4. Alternative Therapy- Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to: acupressure, acupuncture, aroma therapy, behavior modification, behavior training, biofeedback, colonic therapy, dietary products, educational therapy, gambling therapy, hair analysis, herbal therapy, hippo therapy, holistic medicine, homeopathy, hypnotherapy, massage therapy, music therapy, naturopathy; prolotherapy; prolozone therapy, recreational therapy (e.g. dance, music, arts, crafts, aquatic), sleep therapy, Vax-D therapy, and vitamin therapy except as outlined in the Schedule of Covered Services.

5. Ambulance service except as outlined in the Schedule of Covered Services.

6. Any services to the extent that payment for such services is, by law, covered by any governmental agency as a primary Plan.

7. Augmentative Communication Devices, including but not limited to devices utilizing word processing software and voice recognition software.

8. Behavior modification, behavioral or educational disorder services and associated expenses related to confirmation of diagnosis, progress, staging or treatment of behavioral (conduct) problems, ADD, Oppositional Defiant Disorder, learning disabilities.

9. Biofeedback- All biofeedback services and supplies related thereto.

10. Blood Storage - Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, umbilical cord blood harvesting and storage is not a Covered Service.

11. Braces and supports needed for athletic participation including but not limited to school-related athletic activity, or employment.

12. Care Rendered to You by a Relative - Services or supplies provided by an immediate family member or relative, and services or supplies provided by a person who ordinarily resides in a Member's household.

13. Charges by providers for failure to appropriately cancel a scheduled appointment, telephone calls, completion of forms, transfer of records, copying of medical records or generation of correspondence, or annual or monthly administrative fees.

14. Complications from Non-Compliance - Non-emergent services for treatment of complications that

occurred because You did not follow the course of treatment prescribed by a Provider.

15. Corrective Appliances - Corrective appliances used primarily for Cosmetic purposes, including but not limited to cranial prostheses and molding helmets. Except as specified in the Schedule of Covered Services, replacement Coverage for Covered Corrective Appliances is limited to once every two (2) years for irreparable damage and/or normal wear, or a significant change in medical condition.

16. Cosmetic Services and Treatments - Those Services, associated expenses, or complications resulting from Cosmetic Surgery and Services. Cosmetic procedures or treatments include, but are not limited to, treatment for alopecia, blepharoplasty, panniculectomy, pharmacological regimens, plastic surgery, treatment for varicose veins (unless Member is diabetic or has peripheral vascular disease), and non-Medically Necessary dermatological procedures and non-Medically Necessary Reconstructive Surgery. Breast reconstruction following a Medically Necessary mastectomy is not considered Cosmetic and is a Covered Service.

17. Counseling Services and Associated Therapies - Counseling and associated therapies including, but not limited to educational; learning disorder; marriage or relationship; vocational or employment; religious; and sexual disorders/relationship.

18. Custodial Care - Care is considered custodial when it is primarily for meeting personal needs. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, shopping, eating and preparing meals, performing general household services, taking medicine, ventilator dependent care or furnishing other home services mainly to help people in meeting personal, family, or domestic needs to include extraordinary personal needs created by the illness of a Dependent. Custodial care is Excluded regardless of the location or setting. Custodial care includes, but not limited to: care rendered in a boarding home, domiciliary care, long term care, nursing home care, protective care, rest cures and supportive care, and all services related thereto.

19. Dental - Dental care; dental Reconstructive Surgery; dental appliances; dental implants; dentures; dental x-rays including any services or X-ray examinations involving one or more teeth (natural and artificial), the tissue or structure around them, the alveolar process, or the gums; treatment of missing, malpositioned or supernumerary teeth, even if part of congenital anomaly; dental prosthetics; removal of dentiginous cysts, mandibular tori, and odontoid cysts; removal of teeth as a complication of radionecrosis or to prevent systemic infection.

20. Disposable Supplies - Supplies, equipment or personal convenience items including, but not limited to, combs, lotions, bandages, alcohol pads, incontinence pads, surgical face masks, common first-aid supplies, disposable sheets and bags, except for those disposable supplies that are Medically Necessary and outlined in the Covered Services Section above.

21. Durable Medical Equipment (DME) – a. Charges exceeding the total cost of the Maximum Allowable Charge to purchase equipment, if applicable. b. Unnecessary repair, adjustment, or replacement, or duplicates of any such equipment. c. Supplies and accessories that are not necessary for the effective functioning of the Covered equipment. d. Items to replace those that were lost or stolen or prescribed as a result of new technology. e. Items that require or are dependent on alteration of home, workplace, or transportation vehicle. f. Motorized scooters, exercise equipment, hot tubs, pool, saunas. g. Deluxe or enhanced equipment. The most basic equipment that will provide the needed medical care will determine the benefit. h. computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, and seat lifts of any kind. i. Patient lifts, auto tilt charis, air fluidized beds, or air flotation beds, unless approved by Case Management for a Member who is in Case management. J. Portable ramp for a wheelchair. Replacement resulting from malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Member are NOT Covered. There is also no Coverage for replacement of the equipment, device or appliance if the Member is non-compliant with its use as prescribed by the Member's Physician.

22. DME Repair and/or Maintenance - Repair and maintenance for routine servicing such as testing, cleaning, regulating and checking of equipment is not Covered except as specified in the Schedule of Covered Services. Except as specified in the Schedule of Covered Services, repair Coverage is limited to but not inclusive of, adjustment required by wear or by condition change (other than excessive weight gain not related to normal growth patterns in children) when prescribed by a Provider, repairs necessary to make the equipment/appliance serviceable unless the repair cost exceeds the cost of the equipment/appliance.

23. Educational Testing or Educational Services - Those educational services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training.

24. Elective or Voluntary - Those elective or voluntary enhancement procedures, services, and medications (such as testosterone or growth hormone) for purposes, including but not limited to: acne; hair growth; sexual performance; athletic performance; Cosmetic purposes; anti-aging; mental performance; weight loss; Sal abrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition, services performed for the treatment of a scar, even when the medical or surgical treatment has been provided by the Health Plan for the condition resulting in the scar, are not Covered.

25. Exercise equipment, including but not limited to a swimming or therapy pool.

26. Eye examinations, Eye exercises, Eye surgery, Vision aids and Appliances and Vision Therapy - Those health services and associated expenses for examinations to determine the need for or change in prescription or other examination related to wearing eyeglasses or lenses of any type; training or orthoptics, including eye exercises (also referred to as vision therapy or eye training); optometric services; eye surgery, including but not limited to: blepharoplasty, refractive surgery, radial keratotomy, laser corneal resurfacing, LASIK, myopic keratomileusis or other surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring); eyeglasses and contact lenses, including but not limited to prescription inserts for diving masks or other protective eyewear; nonstandard items for lenses including tinting and blending. This exclusion does not apply to: (1) the first pair of contact lenses or eyeglasses following the initial diagnosis of aphakia or the surgical removal or surgical replacement of an organic lens; or 2) hydrophilic contact lenses used as a corneal bandage to treat conditions involving the cornea. Notwithstanding the foregoing, this provision shall not apply to those Pediatric Vision benefits that are Covered Services, as set forth in the “Covered Services” Section of this Contract.

27. Family Planning and Reproductive Services- (a) Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to: (1) artificial insemination; (2) in vitro fertilization; (3) fallopian tube reconstruction; (4) uterine reconstruction; (5) assisted reproductive technology (ART) including but not limited to GIFT and ZIFT; (6) fertility injections; (7) fertility drugs, (8) services for follow-up care related to infertility treatments. (b) Services or supplies for the reversals of sterilizations. (c.) Induced abortion unless: (1) the health care Provider certifies in writing that the pregnancy would (1)endanger the life of the mother, or; (2) the fetus is not viable.

28. Food or Food Supplements and Medical Foods - The cost of outpatient enteral tube feedings, nutritional formula or supplements and supplies, regardless of whether such supplements/foods are the sole source of nutrition, except for low protein foods as described in the Covered Services Section above. Additionally there is no coverage for donor breast milk or the treatment of eating disorders, including, but not limited to anorexia or bulimia.

29. Foot Care - Routine foot care such as removal or reduction of corns and calluses, clipping of nails, treatment of flat feet or fallen arches, arch supports, orthotics, treatment of chronic foot strain, medical or surgical treatment of onychomycosis (nail fungus), trimming of hyper keratotoic lesions,

corrective shoes, shoe inserts, heel elevations, treatment of weak, strained, flat, unstable, or unbalanced feet, treatment of metatarsalgia, and removal of toenails except Medically Necessary surgery for ingrown toenails and routine foot care and orthotics required to treat manifestations of systemic disease causing circulatory problems, such as diabetes or peripheral vascular disease (PVD).

30. Gender Reassignment - Studies, treatments or procedures for sex transformation or sexual identification.

31. Growth Hormone - Growth hormone therapy for any condition or idiopathic short stature, except children less than 18 years of age who have been appropriately diagnosed to have a documented growth hormone deficiency or individuals with Turner's syndrome or HIV wasting syndrome.

32. Hair analysis, wigs and hair transplants.

33. Hearing Services - Includes but not limited to cochlear implants, hearing aids(except for hearing aids covered for children up to the age of eighteen (18) as described above),in the "Covered Services" section of this Contract other hearing implants, audiometric testing associated with these devices and other hearing devices, tinnitus maskers, and any related purchases, adjustments, or services.

34. Home services to help meet personal/family/domestic needs - Services or related to help meet personal, family, and/or domestic needs, including, but not limited to, Home Health aids, activities of daily living such as bathing, dressing, eating and preparing meals, shopping, performing general household services, and taking medication.

35. Hypnotherapy - Therapy undertaken while the Member is in hypnosis.

36. Immunizations and Examinations - Examinations or immunizations for employment, travel, school, camp, sports, licensing, insurance, adoption, marriage or those ordered by a third party.

37. Infertility services and supplies - Any medical service, office visit, lab, diagnostic test, prescription drug, equipment, medicine, supply, or procedure directly or indirectly related to promoting conception by artificial means including but not limited to: artificial insemination (AI);, artificial reproductive technology (ART); egg or sperm donation; egg, ovum or sperm harvest; embryo transplants; intracytoplasmic sperm injection (ICSI); in vitro and in vivo fertilization (IVF) which includes gamete intrafallopian transfer (GIFT) and zamete intrafallopian tube transfer (ZIFT) procedures; selective reduction, cryopreservation and storage of sperm, eggs and embryos; supplies and drug therapies including but not limited human chorionotropin, urofollitropin, menotropins or derivatives; drugs and travel cost for selective reduction, related cost of sperm and egg collection and preparation; non-Medically Necessary amniocentesis; Hospitalizations due to complications of infertility therapies or drugs; and any Infertility treatment deemed Experimental or Investigational.

38. Medical Appliances, Devices, Medical Equipment, or Services - Appliances, devices, equipment, or services including but not limited to equipment that alters air quality or temperature air conditioners; athletic equipment; bathtub assistive devices; batteries and battery chargers; bed-liners; canes; cervical collars; corsets; cranial helmets; dehumidifiers; elastic or leather braces or supports; emergency alert equipment; exercise equipment; expenses incurred at a health spa, gym or similar Facility; filters; grab/tub bars; guest meals and accommodations; heating pads; home improvement items; including but not limited to: escalators, elevators, ramps, stair glides, humidifiers, office chairs; office visits for a non-covered device or supply; mattress covers; rental or purchase of TENS units, sun or heat lamps; take home medications and supplies; traction apparatus; tub benches; telephone; television; wheelchair lifts; and whirlpool baths.

39. Newborn home delivery.

40. Over-the-counter supplies such as ACE wraps/elastic supports/finger splints, orthotics, orthopedic splints, knee braces.

41. Oral Surgery - Except as specified in the "Covered Services" section of this contract, oral and dental surgery and related services and supplies including: orthodontics, periodontics, endodontics, prosthodontics, and preventive, Cosmetic or restorative dentistry, including services and supplies for treatment of congenital abnormalities. Services required as part of an orthodontic treatment program or required for correction of an occlusal defect, including but not limited to removal of symptomatic bony impacted third molars.

42. Temporal mandibular joint surgery or other oral surgery services Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) tooth extraction; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth. b. Treatment for correction of underbite, overbite, and misalignment of the teeth including braces for dental indications.

43. Orthodontia and related services.

44. Pediatric Vision:
    a. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
    b. Medical and/or surgical treatment of the eye, eyes or supporting structures;
    c. Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; including but not limited to industrial or safety glasses.
    d. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
    e. Plano (non-prescription) lenses and/or contact lenses;
    f. Non-prescription sunglasses;
    g. Two pair of glasses in lieu of bifocals;
    h. Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.
    i. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.
    j. Services or materials rendered by a Provider other than an Ophthalmologist, Optometrist, or Optician acting within the scope of his or her license.
    k. Any additional service required outside basic vision analyses for contact lenses, except fitting fees.
    l. Services rendered or materials ordered before the date coverage began under the Covered Policy.
    m. Regardless of Optical Necessity, benefits are not available more frequently than that which is specified.
    n. Allowances are one-time use benefits; no remaining balance.
    o. Discounts do not apply for benefits provided by other benefit Plans.

45. Phase I and II clinical trials for the treatment of cancer.

46. Phase I, II, III, and IV clinical trials for the treatment of diagnoses other than cancer.

47. Psychiatric evaluation or therapy - When related to judicial or administrative proceedings or orders, when employer requested, or when required for school.

48. Psychological testing - Testing including but not limited to the treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders, and behavioral training.

49. Physiotherapy Services - Physiotherapy services (occupational, physical and speech) for psychosocial and/or developmental delays, including, but not limited to mental retardation, cerebral palsy, chronic brain injury, or speech therapy for stuttering. Physiotherapy services (occupational, physical and speech) for work hardening or for recreational purposes, including, but not limited to sports or vocal performance and Services related to the treatment of sensory processing dysfunction or sensory integration disorder. This exclusion does not apply to the initial assessment for diagnosis of the condition or to the medical management of an underlying medical illness which may be contribution to the condition.

50. Private duty nursing.

51. Private inpatient room, unless Medically Necessary or if a semi-private room is unavailable.

52. Personal comfort and convenience items such as television and telephone.

53. Prosthetic - a. Hearing aids for Members age 18 or older; b. prosthetics primarily for Cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants; c. items to replace those that were lost, damaged, stolen, or prescribed as a result of new technology; d. the replacement of contacts after the initial pair have been provided following cataract surgery; e. foot orthotics, shoe inserts, and custom made shoes except as required by law for diabetic patients or as part of a leg brace, and f. penile prosthesis.

54. Robotics - Services performed by robotic equipment.

55. Sterilization reversal.

56. Substance Abuse - substance abuse maintenance therapy such as methadone therapy, and similar drug therapies including clinical and professional services provided specifically for such therapies. Medically Necessary detoxification or Medically Necessary Rehabilitation Services are Covered. Please see Your Schedule of Benefits for limitations.

57. Surgery performed solely to address psychological or emotional factors.

58. Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of a Member acting as a surrogate mother.

59. Transplant Services, screening tests, and any related conditions or complications related to organ donation when a Member is donating organ or tissue to a non-Member.

60. Transplant Services and associated expenses involving temporary or permanent mechanical or animal organs.

61. Travel Expenses - Travel or transportation expenses, even though prescribed by a Provider, except as specified in the Covered Services Section.

62. Treatment of sexual dysfunction - Treatment, services, devices, and supplies related to sexual

dysfunction. This exclusion does not apply to implantation of a penile prosthesis or use of an external device for impotence caused by an organic disease such as diabetes mellitus or hypertension, or caused by surgery for genitourinary cancer.

63. Treatment of mental retardation, unless Covered as a biologically-based mental illness.

64. Treatment for disorders relating to learning, motor skills, communication, and pervasive developmental conditions such as autism, augmentative communication devices, including but not limited to devices utilizing word processing software and voice recognition software.

65. Varicose Veins - Treatment for varicose veins, including but not limited to micro-surgery and laser therapy. The treatment of varicose veins for complications related diabetes and peripheral vascular disease are covered if Medical Necessary.

66. Vocational therapy- Therapy to enable the disabled individual to resume productive employment.

67. War related sickness, injury, services or care for military service-connected disabilities and conditions for which You are legally entitled to Veteran's Administration services and for which facilities are reasonably accessible to You.

68. Services for conditions resulting from war or acts of war.

69. Weight reduction therapy, supplies and services, including but not limited to diet programs, tests, examinations or services and medical or surgical treatments such as intestinal bypass surgery, stomach stapling, balloon dilation, wiring of the jaw and other procedures of a similar nature, except where We determine them to be Medically Necessary.

70. Work hardening programs.

71. Work related injuries or illnesses, including those injuries that arise out of or in any way result from an illness or injury that is work-related, provided the employer provides, or is required to provide, workers' compensation or similar type coverage for such services.

6.3 In addition to the Exclusions and limitations set forth in Sections 6.1 and 6.2, above, the following Exclusions and limitations also apply to outpatient Prescription Drugs.

Limitations:

Prior Authorization. Some Prescription Drugs or Specialty Drugs require Prior Authorization in order to be Covered under Your Prescription Drug benefits. These include, but are not limited to, medications that may require special medical tests before use or that are not recommended as a first-line treatment or that have a potential for misuse or abuse. Drugs requiring Prior Authorization are identified in the Formulary with "PA" next to the name of the drug. Before You can receive Coverage for a Prescription Drug or Specialty Drugs requiring Prior Authorization, the Prescribing Provider must first contact Us Plan by phone, fax or electronic communication in order to obtain, and You must be granted Prior Authorization by Us. For those Drugs requiring Prior Authorization, Coverage for Your Prescription Drug or Specialty Drugs will be delayed until Prior Authorization has been requested from and approval provided by Us.

Step Therapy. Some Prescription Drugs or Specialty Drugs require Step Therapy in order to be Covered under Your Prescription Drug benefits. These include, but are not limited to, medications that are not recommended as a first-line treatment. Drugs requiring Step Therapy are identified in the Formulary with "ST" next to the name of the drug. If when the Participating Pharmacy submits a claim via the online system and the claim is returned to the Participating Pharmacy because it does not find a required first-line treatment in Your claim history, then the Prescribing Provider must obtain Prior Authorization from Us in order for the drug to be Covered.

Specific Quantity Limits. Some Prescription Drugs are subject to specific quantity limits. You can obtain information on specific quantity limits from the searchable Formulary on Our website or by contacting Our Customer Service Department.

Authorized Refills will be provided for the lesser of:

i) twelve (12) months from the original date on the Prescription Order unless limited by state or federal law; or

ii) the number of Refills indicated by the Prescribing Provider.

Coordination of Benefits. There is no coordination of benefits for Your Prescription Drug coverage with other Health Plans except for Medicare Parts B and D. This means that if You have primary drug coverage with another Plan, We do not cover under this Contract the portion of Your Prescription Drug coverage remaining after Your primary coverage has paid.

Coverage of injectable drugs is limited to Self-Administered Injectable Drugs and injectable diabetes agents, bee sting kits, injectable migraine agents and injectable contraceptives that are commonly and customarily administered by the Member.

Except in a Medical Emergency, Self-Administered Injectable Drugs and Specialty Medications are available only from a Specialty Pharmacy unless otherwise Prior Authorized by Us.

We reserve the right to include only one (1) manufacturer's product on the Formulary when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers. The product that is listed on the Formulary will be covered at the applicable Copayment, Deductible or Coinsurance. The product or products not listed on the Formulary will be Excluded from coverage.

We reserve the right to include only one (1) dosage or form of a drug on the Formulary when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms (for example but not limitation, dissolvable tablets, capsules, etc.) from the same or different manufacturers. The product in the dosage or form that is listed on the Formulary will be covered at the applicable Copayment, Coinsurance and/or Deductible. The product or products in other forms or dosages that are not listed on the Formulary will be Excluded from coverage.

Coverage of therapeutic devices or supplies requiring a Prescription Order and prescribed by a prescribing Provider is limited to Plan-approved diabetic test strips and lancets, and contraceptive diaphragms.

Plan-approved blood glucose meters, asthma holding chambers and peak flow meters are Covered Drugs, but are limited to one (1) Prescription Order per year.

Coverage through the Mail Order Pharmacy is not available for drugs that are not Maintenance Drugs as defined by Us, drugs that cannot be shipped by mail due to state or federal laws or regulations, or when We or the Mail Order Pharmacy consider shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, all controlled substances, and anticoagulants.

We reserve the right to limit the location at which You can fill a Covered Drug to a Participating Pharmacy that is mutually agreeable to both the Us and You. Such limitations may be enforced in the event that We identify an unusual pattern of claims for Covered Drugs.

Certain vaccines are Covered when obtained and administered in a Participating Pharmacy by a certified professional. These vaccinations are noted as such in the Formulary.

Other Limitations include the following:

- The number of doses of a Prescription Drug that is Covered during the last two (2) months of this Contract or departure for active military duty may be limited to an amount sufficient to last only until the termination of the Contract.

- Pharmacy shall not dispense and We will not Cover a Prescription Drug order which, in the Pharmacist's professional judgment, should not be filled. For example, a pharmacist may refuse to fill a prescription if he or she believes that filling the prescription is not in the best interest of Your health, may interact badly with another drug You are taking, that an excessive quantity has been prescribed or that the prescription is incomplete or was not issued by the Prescribing Provider whose name appears on the prescription.

- Early fills for vacation or travel out of the country are limited to [once][twice] per calendar year. These early fills are limited to a 30 day supply. Early Refills on controlled substances are not allowed.

- We reserve the right to include only one (1) manufacturer's brand name product on Our Formulary when the same or similar drug (i.e., a drug with the same active ingredient), supply or equipment is made by two (2) or more different brand name drug manufacturers. The product that is listed on Our Formulary will be Covered at the applicable Co-payment level. The product or products of the same drug not listed on the Formulary will be Excluded from Coverage.

- We reserve the right to include only one (1) dosage or form of a drug on Our Formulary when the same drug (i.e., a drug with the same active ingredient) is available in different dosages or forms (i.e., dissolvable tablets, capsules, etc.) from the same or different manufacturers. The product, in the dosage or form that is listed on the Formulary will be Covered at the applicable Co-Payment level. The product or products, in different forms or dosages, not listed on the Formulary will be Excluded from Coverage.

- Maintenance Drugs may only be Covered when dispensed by the Mail Order Pharmacy as described in the Prescription Drugs Section of the Schedule of Covered Services, above.

Exclusions:

The cost of the following Prescription Drugs and products is specifically Excluded from Coverage provided under Your Prescription Drug benefits and is not Covered, **even if** prescribed by a Prescribing Provider and dispensed at a Participating Pharmacy:

1. Any Prescription Drugs, injectables, supplies, devices or other items covered under the Medical Benefit.

2. Prescription Drugs dispensed by Non-Participating Pharmacies, except as described in the ***Limitations*** Section, above.

3. Prescription Drugs not listed in the Formulary, unless the Participating Provider, for valid medical reasons, requests and receives Plan approval in advance of ordering a non-Formulary drug.

4. Drugs and products: (i) from which no significant improvements in physiologic function could be reasonably expected; or (ii) that do not meaningfully promote the proper function of the body or prevent or treat illness or disease; or (iii) is done primarily to improve the appearance or diminish an undesired appearance of any portion of the body. These include but are not limited to, drugs prescribed for the prevention of wrinkles, skin depigmentation or hair restoration or hair loss or drugs whose primary FDA indication is for Cosmetic use. Topical products used in conjunction with chemotherapy or radiation therapy such as but not limited to Biafine.

5. Devices or supplies of any type, even though requiring a Prescription Order unless otherwise specified as a Covered Benefit in Section 5. These include, but are not limited to therapeutic devices, support garments, corrective appliances, non-disposable hypodermic needles, or other devices, regardless of their intended use.

6. Drugs prescribed and administered, in whole or in part, in a Physician's office, medical office, Hospital, or other health care Facility.

7. Implantable time-released medication, including, but not limited to implantable contraceptives.

8. Drugs and products that do not, by federal or state law, require a prescription to be dispensed, such as aspirin, antacids, herbal products, oxygen, medicated soaps, and bandages, or Prescription Drugs with non-Prescription Drug alternatives or over-the counter equivalents (e.g., Benadryl 25 mg) even if prescribed in the generic form, unless as specifically noted in the Formulary.

9. Drugs, oral or injectable, used for the primary purpose of, or in connection with, treating Infertility, fertilization and/or artificial insemination.

10. Fluids, solutions, nutrients, or medication used or intended to be used by intravenous or gastrointestinal (enteral) infusion, or by intravenous injection in the home setting, except as specifically listed as a Covered Service in Section 5.

11. Experimental or Investigational drugs.

12. Growth hormones, except that they are Covered when used to treat a congenital anomaly such as but not limited to Turner's Syndrome.

13. Any Prescription Drug that is being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper; and drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Member identification card, including drugs obtained for use by anyone other than the Member identified on the identification card.

14. Drugs used for athletic performance enhancement or Cosmetic purposes, including, but not limited to anabolic steroids, tretinoin for aging skin, and minoxidil lotion.

15. Injectable medications [other than Self-Administered Injectables or Specialty Drugs defined in this Contract] as designated by Us, Glucagon, Insulin, Imitrex and bee sting kits; (refer to the Covered Services Section of this Contract for information regarding Coverage of injectables under Section 5).

16. Vitamins and minerals, both over-the-counter and legend, except legend prenatal vitamins for pregnant or nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium.

17. Oral dental preparations and fluoride rinses, except fluoride tablets or drops.

18. Refill prescriptions resulting from loss or theft, or resulting from damage by the Member.

19. Compounded prescriptions are Excluded unless all of the following apply:

    i) Except as Authorized by Us, there is no suitable commercially-available alternative available; and

    ii) the main active ingredient is a Covered Drug; and

iii) the purpose is solely to prepare a dose form that is Medically Necessary and is documented by the Prescribing Provider; and

iv) the claim is submitted electronically.

Compounded prescriptions whose only ingredients do not require a prescription are Excluded. Also Excluded are compounded prescriptions for which the major ingredient is not approved by the FDA for the intended use.

20. Prescriptions directly related to non-Covered Services.

21. Any drug or product which is being administered for preparation of or post operatively for sexual transformation and/or gender reassignment.

22. Progesterone for the treatment of premenstrual syndrome (PMS) and compounded natural hormone therapy replacement.

23. Drugs and products used primarily as a part of a smoking cessation program (e.g., oral drugs, Nicorette gum, nasal sprays, inhalers and nicotine patches).

24. The cost of special packaging required for drugs dispensed in nursing homes.

25. Drugs prescribed and taken for the purpose of facilitating travel, including, but not limited to, medications, devices and supplies for motion sickness or travel-related disease (e.g., Relief bands, vaccines).

SECTION 7
COMPLAINTS AND APPEALS

We maintain informal and formal procedures to resolve Member inquiries, Grievances, and Appeals. These processes give Members the opportunity to ask Us to review any matter related to Covered Services, including but not limited to:

- Issues about the scope of Coverage for Health Care Services;
- Denial, cancellation, or non-renewal of Coverage;
- Denial of care/services/claims;
- Member rights; and
- The quality of the Health Care Service received.

7.1 Appointing an Authorized Representative

Grievances and Appeals can be filed by You or Your Authorized Representative. In order to ensure compliance with federal and state privacy laws, We will require You to complete and return an Authorized Representative form before We will discuss any of Your confidential health or financial information with Your Authorized Representative. An Authorized Representative form can be obtained by contacting Us at **855-449-2889.**

7.2 Procedure for Filing a Grievance

If You are not satisfied with an action by Us, You have the right to file a Grievance. We consider all Grievances and will attempt to rectify the situation where appropriate. Grievances may be submitted via telephone by calling Our Customer Service Organization at **855-449-2889**or may be submitted in writing to the following address:

[Coventry Health and Life Insurance Company
Attention: Appeals Department
3838 N. Causeway Blvd.
Suite 3350
Metairie, Louisiana 70002]

7.3 Medical Necessity Denials

A **Medical Necessity Denial** is a medical determination where We denied, reduced, or terminated a treatment, service, or supply based on Medical Necessity, medical appropriateness, health care setting, level of care, or effectiveness.

A. Informal Peer-to-Peer Reconsideration

In the event that We issue a Medical Necessity Denial, We shall give the treating Provider an opportunity to request an informal peer-to-peer reconsideration. A request for a peer-to-peer reconsideration must be received within ten (10) calendar days of the initial denial. We will contact the treating Provider requesting the peer-to-peer reconsideration within one (1) business day of receiving the request.

B. Medical Necessity Appeals

A **Medical Necessity Appeal** is an Appeal of a Medical Necessity Denial, as defined above. There are three types of Medical Necessity Appeals:

- **Pre-Service Medical Necessity Appeals** are Medical Necessity Appeals for which We have denied Prior Authorization for a Covered Service and You are Appealing before the Covered Service has been rendered.

- **Expedited Pre-Service Medical Necessity Appeals** are a special type of Pre-Service Medical Necessity Appeal in which the Appeal must be reviewed in an expedited manner because a delay in review could seriously jeopardize: (a) the life or health of the Member; or (b) the Member's ability to regain maximum function. In determining whether an Appeal involves Urgent or Emergency Care (e.g. to screen and stabilize the patient) requiring expedited review, We will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. We will also review a Pre-Service Medical Necessity Appeal in an expedited manner when: (a) Your treating Physician deems the care to be Urgent in nature; or (b) Your treating Physician determines that delaying the care would subject You to severe pain that cannot be adequately managed without the care or treatment that is being requested. An expedited Appeal may be initiated by the Member with the consent of the treating Physician or by the Physician acting on behalf of the Member.

- **Post-Service Medical Necessity Appeals** are Medical Necessity Appeals for which We have denied a Covered Service and You are Appealing after the Covered Service has been rendered.

C. How To Submit a Medical Necessity Appeal

Members may submit a Medical Necessity Appeal request to Us by telephone, fax, or mail to the following address:

[Coventry Health and Life Insurance Company
Attention: Medical Necessity Appeals Department
3838 N. Causeway Blvd.
Suite 3350
Metairie, Louisiana 70002]
[855-449-2889]

A Medical Necessity Appeal request must include the following information.

- Patient name, identification number, address, phone number, and date of birth;
- Member name, identification number, address, phone number, and date of birth;
- Member's Authorized Representative's name, mailing address, phone number, and fax number (if Member has appointed an Authorized Representative);
- Provider/Facility name, address, phone number, and fax number;
- Dates of service under Appeal;
- Whether Your Medical Necessity Appeal is Pre- or Post-Service, and if Pre-Service, whether or not You believe Your Medical Necessity Appeal qualifies for Expedited treatment;
- Clear indication of the remedy or corrective action being sought and an explanation of why the Plan should "reverse" Our denial; and
- Documentation to establish the Medical Necessity of the Covered Service (e.g. any and all medical records related to Your Appeal, other information from Your treating Physician, scientific/medical research, etc.).

If You are submitting Your Appeal request by telephone, You have seven (7) calendar days from the date of this telephone request to mail Your documentation to Us, including any and all medical records related to Your Appeal.

You may also request - free of charge - copies of the documents, records, and other information relevant to the medical determination that resulted in Your Medical Necessity Denial.

Your written request for a Medical Necessity Appeal must be filed within one hundred and eighty (180) calendar days after the date that We send notice of the initial denial to You. Medical Necessity Appeal requests that are submitted after one hundred eighty (180) calendar days will not be considered.

D. First Level Medical Necessity Appeal

Our Medical Necessity Appeal process has two levels. The First Level Medical Necessity Appeal will be conducted by a licensed Physician. The Physician reviewing Your First Level Medical Necessity Appeal will be a person who was not involved in the initial denial and who is not a subordinate of the person who issued the initial denial.

The First Level Medical Necessity Appeal will consider all comments, documents and records submitted by You and Your treating Providers regardless of whether this information was submitted to Us at the time the initial denial was issued. You may request identification of any vocational or medical expert whose advice was obtained in connection with Your First Level Medical Necessity Appeal (as applicable).

- **Pre-Service Medical Necessity Appeal Decisions--** We will notify You in writing of a First Level Pre-Service Medical Necessity Appeal decision within five (5) business days from determination, and within thirty (30) calendar days of Our receipt of Your Appeal and supporting information.

- **Expedited Pre-Service Medical Necessity Appeal Decisions--** In situations involving Expedited Pre-Service Medical Necessity Appeals, We will verbally notify You of Our determination as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after Our receipt of Your Appeal and supporting information. Verbal notification will be followed by written confirmation within three (3) calendar days.

- **Post-Service Medical Necessity Appeal Decisions--** We will notify You in writing of a First Level Post-Service Medical Necessity Appeal decision five (5) business days from determination, and within thirty (30) calendar days of Our receipt of Your Appeal and supporting information.

E. Second Level Medical Necessity Appeal

If You are not satisfied with Your First Level Medical Necessity Appeal decision, You may Appeal Your case to the Second Level Medical Necessity Appeal Committee. The Second Level Medical Necessity Appeal Committee is composed of one (1) to three (3) senior managers. The Second Level Medical Necessity Appeal Committee will include at least one licensed health care professional in the same or similar Specialty as typically manages the treatment or service under review and who must concur with any denial by the Second Level Medical Necessity Appeal Committee. The Second Level Medical Necessity Appeal Committee will not include the Physician who issued the First Level Medical Necessity Appeal decision.

The Second Level Medical Necessity Appeal Committee will consider all comments, documents and records submitted by You and Your treating Providers for the First Level Medical Necessity Appeal, as well as any additional materials that You wish to submit for consideration by the Second Level Medical Necessity Appeal Committee. **In addition, You and/or Your Authorized Representative (as applicable) have the right to appear before the Second Level Medical Necessity Appeal Committee to present Your case to the Committee.** If You are unable to attend the Committee meeting in person, We will arrange for You to participate by conference call.

In order to obtain a Second Level Medical Necessity Appeal, You must submit a request by telephone, fax, or by mail to the following address:

[Coventry Health and Life Insurance Company
Attention: Medical Necessity Appeals Department
3838 N. Causeway Blvd.
Suite 3350
Metairie, Louisiana 70002]
[855-449-2889]

If You want to submit additional information for consideration by the Second Level Medical Necessity Appeal Committee that was not submitted as part of Your First Level Medical Necessity Appeal, You must include this information in Your request for a Second Level Medical Necessity Appeal. You may also request- free of charge- **copies of** the documents, records, and other information relevant to Your First Level Medical Necessity Appeal decision.

If You are not satisfied with the decision of the Second Level Medical Necessity Appeal Committee, You may pursue normal remedies of law, including the External Review process described below and Your rights under ERISA Section 502(a) as applicable.

- **Pre-Service Medical Necessity Appeal Decisions--** We will notify You in writing of a Second Level Pre-Service Medical Necessity Appeal decision within five (5) calendar days from determination and within thirty (30) calendar days of Our receipt of Your Appeal and supporting information.

- **Expedited Pre-Service Medical Necessity Appeal Decisions--** In situations involving Second Level Expedited Pre-Service Medical Necessity Appeals, We will verbally notify You of Our determination as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after Our receipt of Your initial Appeal and supporting information. Verbal notification will be followed by written confirmation within three (3) calendar days.

- **Post-Service Medical Necessity Appeal Decisions--** We will notify You in writing of a Second Level Post-Service Medical Necessity Appeal decision within five (5) calendar days from determination and within thirty (30) calendar days of Our receipt of Your Appeal and supporting information.

F. External Review

You have the right to request an **External Review** of a Medical Necessity Denial once You have completed Your First Level and Second Level Medical Necessity Appeals as long as Your treating Provider concurs With Your decision to pursue External Review. Your External Review will be conducted by an Independent Review Organization (“IRO”) that is licensed and regulated by the Louisiana Department of Insurance. The IRO shall also be accredited by a nationally recognized accrediting organization.

If You would like to request External Review by an IRO, You must submit a written request sent by fax or by mail to the following address:

[Coventry Health and Life Insurance Company
Attention: Medical Necessity Appeals Department
3838 N. Causeway Blvd.
Suite 3350
Metairie, Louisiana 70002]
[855-449-2889]

You must submit Your request to Us in writing within six (6) months after You receive Your Second Level Medical Necessity Appeal Committee decision. If Your request is eligible for external review,

Your request will be forwarded to an assigned IRO, along with a copy of the documentation and information that was considered by the Second Level Medical Necessity Appeal Committee and also notify You or Your representative of the right to submit additional information. The IRO will provide notice of its recommendation to Us in writing within forty-five (45) calendar days after the date that the IRO receives Your information from Us, and We will provide notice to You within 3 business days of receipt of the IRO's recommendation.

You may request an External Review prior to exhausting the second level of Appeal, if: i) You have an Emergency Medical Condition; or ii) We decide to waive the requirements for the First Level Medical Necessity Appeal, Second Level Medical Necessity Appeal, or both; iii) We have failed to comply with the requirements of the internal Appeals process unless such a failure does not cause, and is not likely to cause, prejudice or harm to the person filing the Appeal; or iv) You or Your representative simultaneously request an expedited internal Appeal and an expedited External Review.

Your treating Provider may request an expedited External Review in situations involving an Expedited Pre-Service Medical Necessity Appeal. Requests for an expedited External Review should be submitted to Us in writing. The IRO will respond to Your External Review request within seventy-two (72) hours from the time that the IRO receives Your information from Us.

7.4 Administrative Denials

A. An **Administrative Denial** is a determination that a health care treatment, service, or supply is not a Covered Service under the terms of Your benefit Plan. **Administrative Denials are not based on a medical determination.** For example, We will issue an Administrative Denial if You request a service that is listed under the Exclusions and Limitations Section of Your Contract of Coverage (Section 6 because these services are not Covered under the terms of Your insurance policy. Appeals challenging Our Out-of-Network payment rates or denials for lack of Prior Authorization will also be handled as Administrative Denials.

Administrative Denials are subject to only one level of review (an "Administrative Appeal"). There are two types of Administrative Appeals:

- **Pre-Service Administrative Appeals** are Administrative Appeals for which We have denied Prior Authorization for a Covered Service and You are Appealing before the Covered Service has been rendered.

- **Post-Service Administrative Appeals** are Administrative Appeals for which We have denied a Covered Service and You are Appealing after the service has been rendered.

In order to request an Administrative Appeal, You may submit a request to Us by telephone, fax, or by mail to the following:

[Coventry Health and Life Insurance Company
Attention: Administrative Appeals Department
3838 N. Causeway Blvd.
Suite 3350
Metairie, Louisiana 70002]
[855-449-2889]

An Administrative Appeal request must include the following information:

- Patient name, identification number, address, phone number, and date of birth;
- Member name, identification number, address, phone number, and date of birth;
- Member's Authorized Representative's name, mailing address, phone number, and fax number (if Member has appointed an Authorized Representative);

- Provider/Facility name, address, phone number, and fax number;
- Dates of service under Appeal;
- Whether Your Administrative Appeal is Pre- or Post-Service, and if Pre-Service, whether or not You believe Your Appeal qualifies for Expedited treatment;
- Clear indication of the remedy or corrective action being sought and an explanation of why We should "reverse" Our denial; and Documentation to support the reversal of Our decision (including any and all medical records related to the service under review).

If You are submitting Your request for an Administrative Appeal by telephone, You have seven (7) calendar days from the date of this telephone request to mail Your documentation to Us.

You may also request, free of charge, copies of the documents, records, and other information relevant to Your Administrative Denial.

Administrative Appeal requests must be filed within one hundred eighty (180) calendar days after the initial notice of denial has been sent to the Member. **Administrative Appeal requests that are received after one hundred eighty (180) calendar days will not be processed.** Administrative Appeals will be presented to the Administrative Appeal Committee, which consists of one (1) to three (3) senior managers of the Plan who were not involved in the original denial. Administrative Appeals do not involve an in-person or telephonic hearing.

- **Pre-Service Administrative Appeal Decisions--** We will notify You in writing of a Pre-Service Administrative Appeal decision within five (5) business days from determination and within thirty (30) calendar days of Our receipt of Your Appeal and supporting documentation.

- **Post-Service Administrative Appeal Decisions –** We will notify You in writing of a Post-Service Administrative Appeal decision within five (5) business days from determination and within sixty (60) calendar days of Our receipt of Your Appeal and supporting documentation.

If You are not satisfied with the decision of the Administrative Appeal Committee, You may have the right to bring civil action under ERISA Section 502(a).

B. Administrative Denials Involving a Law Enforcement Investigation

In the event that You obtain an Injury or Illness as a result of Your involvement in an incident or accident that is under investigation by the police or other law enforcement officials, We will request a copy of the incident or accident report from the applicable law enforcement offices, as well as copies of all of Your medical records related to the Injury or Illness. If all or a portion of the accident or incident report has not been released at the time of Your Administrative Appeal (including alcohol and toxicology reports as applicable), We will make the decision to approve or deny payment of Your claims based on the information that is accessible to Us at that time. However, please be advised that We may re-open Our decision at a later date if new material information becomes available to Us, such as an official investigation report, alcohol or toxicology test results, or medical records that were not accessible to Us on the date of Your Administrative Appeal. In the event that We make a different benefit determination based on this new material information, You will be given the right to another Administrative Appeal. Please be advised that We reserve the right to rely on the content of an official accident or incident report in making Our benefit determination (including alcohol and toxicology test results as applicable), regardless of whether criminal charges are ultimately pursued by the government or a conviction actually occurs.

If We discover that You or Your Authorized Representative intentionally withheld material information and/or materially misrepresented information related to Your Injury or Illness during Your Administrative Appeal, We may initiate a fraud investigation, which could result in the termination of Your Health Insurance Coverage.

7.5 Appeals Regarding Loss of Eligibility Due to Non-Payment of Premium

All Appeals regarding loss of eligibility due to non-payment of Premium must be submitted to the Health Insurance Marketplace, not CHL. Pursuant to federal regulation, all such Appeals shall be determined by the Health Insurance Marketplace.

7.6 Appeals Regarding Advance Premium Tax Credit

All Appeals relating to advance Premium tax credit, including but not limited to eligibility for such credit or the proper amount of such credit, must be submitted to the Exchange, not CHL. Pursuant to federal regulation, all such Appeals shall be determined by the Health Insurance Market.

SECTION 8
CONFIDENTIALITY OF YOUR HEALTH INFORMATION

We work hard to keep Your personal health information secure and private. You will receive a copy of Our Notice of Privacy Practices upon Your enrollment. This notice fully explains how We may use and share Your information. The notice is posted on Our web site at www.chctn.com, and You can also request another copy by calling Customer Service at **855-449-2889**. In general, We can access and disclose Your records and medical information as permitted under the privacy regulations set forth at 45 C.F.R. Part 164 and promulgated pursuant to the Federal Health Insurance Portability and Accountability Act of 1996.

Genetic Testing. In the event that We receive information derived from genetic testing that You have undergone, We agree not to use this information for any non-therapeutic purpose. We further agree not to release this information to any third party without Your explicit written consent.

SECTION 9
RIGHT OF RECOVERY

TENNESSEE
Right of Recovery

As used herein, the term "Third Party", means any party that is, or may be, or is claimed to be responsible for illness or injuries to You. Such illness or injuries are referred to as "Third Party Injuries." "Third Party" includes any party responsible for payment of expenses associated with the care of treatment of Third Party Injuries.

If this Plan pays benefits under this Contract to You for expenses incurred due to Third Party Injuries, then the Plan retains the right to repayment of the full cost of all benefits provided by this Plan on behalf of You that are associated with the Third Party Injuries. The Plan's rights of recovery apply to any recoveries made by, or on behalf of, You from the following sources including, but not limited to:

- Payments made by a Third Party or any insurance company on behalf of the Third Party;
- Any payments or awards under an uninsured or underinsured motorist Coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments Coverage under any automobile policy, premises, or homeowners' medical payments Coverage or premises or homeowners' insurance Coverage; and
- Any other payments from a source intended to compensate You for medical expenses arising from Third Party injuries.

By accepting benefits under this Plan, You specifically acknowledge the Plan's right of subrogation. When the Plan pays health care benefits for expenses incurred due to Third Party Injuries, the Plan shall be subrogated to Your rights of recovery against any party to the extent of the full cost of all benefits provided by this Plan. The Plan will notify You or Your representative of its interest and maintain contact throughout the process.

By accepting benefits under this Plan, You also specifically acknowledge the Plan's right of reimbursement. This right of reimbursement attaches when this Plan has paid health care benefits for expenses incurred due to Third Party Injuries and You or Your representative has recovered any amounts from a Third Party or the sources outlined above. The Plan's right of reimbursement is cumulative with and not exclusive of its subrogation right and it may choose to exercise either or both rights of recovery. The Plan will notify You or Your representative of its interest and maintain contact throughout the process.

You or Your representative agrees to cooperate with the Plan and do whatever is necessary to secure the Plan's rights of subrogation and reimbursement under this Contract. This includes notifying the Plan promptly and in writings when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries. You or Your representative will do nothing to prejudice the Plan's rights as set out above. This includes, but is not limited to, refraining from making settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the Plan. Failure to cooperate with the Plan as outlined herein will operate as an assignment to the Plan of the proceeds of any settlement, judgment or other payment received by You to the extent of the full cost of all benefits provided by the Plan.

[When Your Health Plan is governed by ERISA, the Plan's recovery rights will be a first priority claim even if the payment of such claim results in a recovery to You which is insufficient to compensate You in part or in whole for the damages they sustained. Also, if Your Health Plan is governed by ERISA, no court costs or attorney fees may be deducted from the Plan's recovery.

For Health Plans not governed by ERISA, the Plan's recovery rights will not be exercised until You are fully compensated for the damages You sustained. Additionally, for Health Plans not governed by ERISA, the Plan will reduce its recovery claim by a proportional share of court costs or attorney fees incurred by You in obtaining a recovery.]

SECTION 10
COORDINATION OF BENEFITS

10.1 This Coordination of Benefits provision applies when You are entitled to Covered Services under this Plan and one or more other health benefit Plans (as defined below). This method of coordination of benefits is sometimes referred to as the "Benefit less Benefit" or non-duplication of benefits method. Unless required by law to pay first, We will pay after Your other health benefit Plan and may reduce the benefits We pay according to the terms of this Plan.

10.2 For purposes of this Section 10, "health benefit Plan" means any of the following that provides benefits or services for medical or dental care or treatment:

> insurance, closed panel or other forms of individual, group or group-type payment (whether insured or uninsured); Hospital indemnity benefits in excess of $200 per day; medical care components of long-term care Contracts such as skilled nursing care; Medical Benefits under group or individual automobile Contracts; and Medicare, or other governmental benefits as permitted by law.

"Health benefit Plan" does not include: amounts of Hospital indemnity insurance of $200 or less per day; school accident type payment, benefits for non-medical components of group long-term care policies; Medicaid policies and payment under other governmental Plans, unless permitted by law.

10.3 When this Plan is secondary, benefits under the primary Plan shall be coordinated with benefits provided under this Plan in order to avoid duplicate payment. If the benefits under the primary Plan for which You are seeking payment are less than the benefits set forth in this Plan and this Plan is secondary, this Plan shall Cover the difference between such benefits under the primary Plan and the benefits set forth in this Plan. If the benefits under the primary Plan for which You are seeking payment are equal to or exceed the benefits set forth in this Plan and this Plan is secondary, this Plan shall not provide any additional payment or pay any additional amounts.

SECTION 11
GENERAL PROVISIONS

11.1 Applicability.

The provisions of this Contract shall apply equally to the Subscriber and Dependents. All benefits and privileges made available to You shall be available to Your Dependents.

11.2 Choice of Law.

This Contract will be administered under the laws of the State of Tennessee.

11.3 Discounts and Rebates.

As a Member of this Plan, You understand and agree that this Plan may receive a retrospective discount or rebate from a Participating Provider or vendor, related to the aggregate volume of services, supplies, equipment or pharmaceuticals purchased by Members enrolled in any Coventry Plan. Though Members shall not share in such retrospective volume-based discounts or rebates, such aggregated rebates will be considered in Our prospective Premium calculations.

11.4 Discretionary Authority.

We shall have the right, subject to Your rights under the Contract, to interpret the benefits of the Contract, applicable Riders, terms, conditions, limitations, and Exclusions set out in the Contract in making factual determinations related to the Contract, its benefits, and Members and in construing any disputed or ambiguous terms.

11.5 Entire Agreement.

This Contract shall constitute the entire agreement between the parties. This Contract is comprised of this Individual Member Contract, Schedule of Benefits and Covered Services, applicable Riders, and Amendments.

11.6 Exhaustion of Administrative Remedies.

You may not bring a cause of action hereunder in a court or other governmental tribunal, unless and until all administrative remedies set forth in this Contract have first been exhausted.

11.7 Misstatements.

Statements and descriptions in any application for an insurance policy during negotiations for such policy by or on behalf of the insured shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or Contract, unless they are fraudulent or material to the acceptance of the risk by the insurer, the hazard assumed by the insurer, or the insurer in good faith would either not have issued the policy or Contract in as large an amount or at the Premium rate as applied for or would not have provided Coverage with respect to the hazard resulting in the loss if the true facts had been known to the insurer as required either by the application for the policy or Contract or otherwise.

11.8 Nontransferable.

No person other than You is entitled to receive Coverage for health care services or other benefits to be furnished by Us under this Contract. Such right to Covered health care services or other benefits is not transferable.

11.9 Policies and Procedures.

We may adopt policies, procedures, rules, and interpretations to promote orderly and efficient administration of this Agreement.

11.10 Relationship Among Parties Affected by Contract.

The relationship between CHL and Participating Providers is that of independent Contractors. Participating Providers are not agents or employees of CHL nor is any employee of CHL an employee or agent of Participating Providers. Participating Providers shall maintain the Provider-patient relationship with You and are solely responsible to You for all Participating Provider services.

11.11 Reservations and Alternatives.

We reserve the right to Contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein.

11.12 Severability.

In the event that any provision of this Contract is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Contract, which shall continue in full force and effect in accordance with its remaining terms.

11.13 Valid Amendment.

No change in this Contract shall be valid, unless approved by an officer of CHL and evidenced by endorsement on this Contract and/or by amendment to this Contract and agreed to, in writing, by You, as required in accordance with regulations promulgated according to the State of Tennessee and federal guidelines. Such amendment will be incorporated into this Contract.

11.14 Waiver.

The failure of CHL or You to enforce any provision of this Contract shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Contract shall not be deemed or construed to be a waiver of such default.

SECTION 12
DEFINITIONS

Any capitalized terms listed in this section shall have the meaning set forth below whenever the capitalized term is used in this Contract.

12.1 Allowed Amount.

Maximum amount on which payment is based for Covered health care services. This may be called "eligible expense," "payment allowance," or "negotiated rate." If Your Provider charges more than the Allowed Amount, You may have to pay the difference.

12.2 Appeal.

A request for Your health insurer or Plan to review a decision or a Grievance again.

12.3 Authorization, Authorize or Prior Authorization.

CHL has given approval for payment for certain services to be performed and an Authorization number has been assigned. Upon Authorization, all inpatient Hospital stays are then subject to concurrent review criteria established by CHL. If You need specialty services from a Non-Participating Provider, an Authorization means the Member's PCP or OB-GYN Physician has recommended a Non-Participating Provider for treatment of a specific condition, and CHL has assigned an Authorization for a certain number of visits or days. Authorization does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

12.4 Coinsurance.

Your share of the costs of a Covered health care service, calculated as a percentage (for example, 20%) of the Allowed Amount for the service. You pay Coinsurance *plus* any Deductibles You owe. For example, if Our Allowed Amount for an office visit is $100 and You've met Your Deductible, Your Coinsurance payment of 20% would be $20. We pay the rest of the Allowed Amount.

12.5 Contract.

The Individual Member Contract, Schedule of Benefits, Covered Services, and Exclusions, and all applicable Riders, Amendments, and endorsements together form the Contract.

12.6 Convenience Care.

A condition that requires Convenience Care is an unexpected illness or injury that does not constitute an Emergency Medical Condition or an urgent situation but requires medical attention when You cannot see Your family doctor right away. Examples of Convenience Care conditions include minor sicknesses, rashes, ear aches, sore throats, stomach aches, and similar problems. Convenience Care Centers are also useful for flu shots, vaccinations, and other shots.

12.7 Copayment.

A fixed amount (for example, $15) You pay for a Covered health care service, usually when You receive the service. The amount can vary by the type of Covered health care service, device, supply and/or drug. If the Allowed Amount for the Covered Service or Covered Drug is less than Your Copayment, You will pay the Allowed Amount..

12.8 Cosmetic Services and Surgery.

Surgery or supplies to change the texture or appearance of the skin or the relative size or position of any part of the body when such surgery is performed primarily for psychological purposes and is

not needed to correct or substantially improve a bodily function or prevent or treat illness or disease unless mandated by law. Removal of skin lesions is considered Cosmetic unless the lesions interfere with normal body functions or malignancy is suspected.

12.9 Coventry Transplant Network Facility.

A Provider or Facility designated by Us to provide transplant services and treatment to Members.

12.10 Covered Drug

The Prescription Drugs and Specialty Drugs that are prescribed by a Prescribing Provider, included on Our current Formulary, approved by Us and not otherwise Excluded from Coverage in this Contract. A list of Covered Drugs can be found on Our website, along with criteria for their approval. Some Covered Drugs may not be Authorized for Coverage as a treatment for Your diagnosis.

12.11 Covered Services or Coverage.

The services and supplies provided to You for which CHL will make payment, as described in the Contract.

12.12 Customer Service and Customer Service Department.

Our Customer Service Department is available to answer any questions or concerns You may have about Your Coverage or Our policies or procedures, including, but not limited to, verification of benefits, Prior Authorization requirements, coordination of benefits information, and procedures for filing an Inquiry or Complaint. You may reach Our Customer Service Department at the telephone number on Your Member ID card.

12.13 Deductible.

The amount You owe for health care services before We begin to pay. For example, if Your Deductible is $1,000, Your Plan will not pay anything until You have met Your $1,000 Deductible for Covered Services subject to the Deductible. The Deductible may not apply to all services.

12.14 Dependent.

Any member of a Subscriber's family, who meets the eligibility requirements as outlined in this Contract.

12.15 Directory of Health Care Providers.

A paper or electronic listing of Participating Providers. Please be aware the information in the Directory is subject to change.

12.16 Durable Medical Equipment (DME).

Equipment and supplies ordered for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics. Please see Section 5 for the specifics of Your Coverage.

12.17 Emergency Medical Condition.

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

12.18 Emergency Room Care.

Emergency Services received in an Emergency room.

12.19 Emergency Services.

Evaluation of an Emergency Medical Condition and treatment to keep the condition from getting worse.

More specifically, Emergency Services means those health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his/her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

- Placing the Member's health in serious jeopardy;
- Placing the health of a pregnant Member and the health of her unborn child in serious jeopardy;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

If You received Emergency Care for services Covered under this Contact, and cannot reasonably reach a Participating Provider, You will pay the same amount to a Non-Participating Provider for the Emergency Covered Service that You would have paid to a Participating Provider.

12.20 Excluded Services.

Health care services that We do not pay for or provide Coverage for.

12.21 Experimental or Investigational.

A health product or service is deemed Experimental or Investigational <u>if one or more of the following conditions are met</u>:

- Any drug not approved for use by the FDA; any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature; or any drug that is classified as IND (Investigational new drug) by the FDA. As used herein, off-label prescribing means prescribing Prescription Drugs for treatments other than those stated in the labeling approved by the FDA;
- Any health product or service that is subject to the Investigational Review Board (IRB) review or approval;
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, III, or IV as set forth by FDA regulations, subject to Section 6;
- Any health product or service whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed, Medical Literature.

12.22 Formulary.

A listing of specific generic and brand name Prescription Drugs which are approved by Us and will be dispensed to You through a Participating Pharmacy. This listing is subject to periodic review and modification by Us at Our discretion The Formulary is available for review on Our website, or by contacting Our Customer Service Department.

12.23 Free Standing Facility.

A Facility not affiliated with a Hospital.

12.24 Grievance.

A complaint that You communicate to Us.

12.25 Habilitative Services.

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

12.26 Health Insurance.

The Contract that requires that We pay some or all of Your health care costs for Covered Services in exchange for a Premium.

12.27 Health Insurance Marketplace.

Means the governmental agency or non-profit entity that the U.S. Department of Health and Human Services has recognized as the organization that shall serve as the Health Insurance Marketplace for the geographic area in which the Subscriber resides.

12.28 Health Plan.

Coventry Health and Life Insurance Company.

12.29 Home Health Care.

Health care services a person receives at home. Please see Section 5, Covered Services for the specifics of Your Coverage.

12.30 Hospice Services.

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

12.31 Hospital.

An institution, operated pursuant to law, which: (a) is primarily engaged in providing health services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; (b) has twenty-four (24) hour nursing services on duty or on call; and (c) is accredited as a Hospital by the Joint Commission or the American Osteopathic Hospital Association, or certified under Title XVIII of the Social Security Act (the Medicare program). A Facility that is primarily a place for rest, custodial care or care of the aged, a nursing home, convalescent home or similar institution is not a Hospital.

12.32 Hospitalization.

Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

12.33 Hospital Outpatient Care.

Care in a Hospital that usually doesn't require an overnight stay.

12.34 In-Network Coinsurance.

The percent (for example, 20%) You pay of the Allowed Amount for Covered Services to Providers who Contract with Us. In-Network Coinsurance usually costs You less than Out-of-Network Coinsurance.

12.35 In-Network Copayment.

A fixed amount (for example, $15) You pay for Covered health care services to Providers who Contract with Us. In-Network Copayments usually are less than Out-of-Network Copayments.

12.36 In-Network Provider, Participating Provider, or Preferred Provider.

A Provider who has entered into a direct or indirect Contract with Us to provide services to You at a discount. Check Your policy to see if You can see any Preferred Providers or if We have a tiered Network and You must pay extra to see some Providers.

12.37 Mail Order.

A [90-93]-day supply of an approved Maintenance Drug obtained through a Participating Mail Order Pharmacy.

12.38 Mail Order Pharmacy.

Where applicable, a Participating Pharmacy Contracted by Us to provide Maintenance Drugs through the mail.

12.39 Maintenance Drug(s).

Those Prescription Drugs which are prescribed for long-term or chronic conditions, such as high blood pressure or diabetes, not written for episodic treatments of medical conditions, and designated by Us as Maintenance Drugs. The list of Maintenance Drugs is available for review on Our website, or by contacting Our Customer Service Department .

12.40 Maximum Allowable Cost (MAC).

The price assigned to Prescription Drugs that will be Covered at the generic product level, subject to periodic review and modification by Us.

12.41 Medical Benefit.

Those Covered Services set forth in Section 5 that are not described or included in the Prescription Drugs Section of the Schedule.

12.42 Medical Director.

The Physician specified by Us as the Medical Director**.**

12.43 Medically Necessary / Medical Necessity.

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine**.**

Medically Necessary means those services, supplies, equipment, and facilities charges that are not expressly Excluded under this Contract and determined by Us to be:

- Medically appropriate, which means that the expected health benefits (such as increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks. The phrase "medically appropriate" embodies the concepts known as "the art of medicine," and "standard of care." It stands to reason that the expected health benefits (outcomes) must outweigh the risks for a service to be deemed Medically Necessary. The service should be demonstrably superior to alternatives, including no service at all;

- Services or supplies that are consistent with the diagnosis of Your medical condition;

- Necessary to meet Your basic health needs as a minimum requirement;

- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service, without compromising the quality of care;

- With respect to drugs, the drug is the most cost-efficient drug for treatment of the Member's condition without compromising the quality of care;

- Consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations, or governmental agencies that are generally accepted by the Plan;

- Required for reasons other than comfort or convenience of the Member or Member's family or convenience of Your Physician;

- Not Experimental or Investigational as determined by Us under Our Experimental or Investigational procedures determination policy;

- Necessary to meet Your basic health needs as a minimum requirement; and

- Of demonstrated value based on the clinical evidence reported by the Peer-Reviewed published medical literature, generally accepted standards of medical practice, the evidence-based guidelines from nationally recognized professional health care organizations and by generally recognized academic medical experts; that is, it is not Experimental or Investigational.

For purposes of this definition, "service" refers to health care services, procedures, equipment, devices and/or drugs.

12.44 Member.

Any Subscriber, Dependent, or Qualified Beneficiary, as that term is defined under COBRA, who enrolled for Coverage under this Contract in accordance with its terms and conditions.

12.45 Member Effective Date.

The date entered on Our records as the date when Coverage for a Member under this Contract begins in accordance with the terms of this Contract, which Coverage shall begin at 12:01 a.m. on such date.

12.46 Network.

The facilities, Providers and suppliers We have Contracted with to provide health care services.

12.47 Non-Formulary Drugs.

Prescription Drugs that are that are not included on Our Formulary at the time the Prescription Drug is dispensed to a Member. Non-Formulary Drugs may include either generic or brand-name Prescription Drugs.

12.48 Non-Participating Pharmacy.

Any registered, licensed pharmacy with whom Our pharmacy benefit administrator or We do not have a Contract.

12.49 Non-Preferred Pharmacy.

A Pharmacy that is a Participating Pharmacy, but is not a Preferred Pharmacy.

12.50 Non-Preferred Provider, Non-Participating Provider, or Out-of-Network Provider.

A Provider who doesn't have a Contract with the Us to provide services to You. You'll pay more to see a Non-Preferred Provider. Check Your policy to see if You can go to all Providers who have Contracted with Us, or if We have a tiered Network and You must pay extra to see some Providers.

12.51 Out-of-Network Coinsurance.

The percent (for example, 40%) You pay of the Allowed Amount for Covered Services to Providers who do *not* Contract with Us. Out-of-Network Coinsurance usually costs You more than In-Network Coinsurance.

12.52 Out-of-Network Copayment.

A fixed amount (for example, $30) You pay for Covered Services from Providers who do not Contract with Us. Out-of-Network Copayments usually are more than In-Network Copayments.

12.53 Out-of-Network Rate (ONR).

The Allowed Amount for Covered Services rendered by Non-Participating Providers for Out-of Network Covered Services. See Section 1.7 for more information on the Out-of-Network Rate.

12.54 Out-of-Pocket Maximum.

The limit on the total amount of Coinsurance, Copayments and Deductibles You must pay out of Your pocket annually for In-Network Covered Services.

12.55 Participating Pharmacy.

Any registered, licensed retail pharmacy with whom the pharmacy benefit administrator or We have a Contract with to dispense Prescription Drugs to Members.

12.56 Participating Provider

A Provider within the Carelink [Hospital Provider] Network] who has entered into a direct or indirect written agreement with the Plan to provide Health Services to Members. The participation status of Providers may change from time to time.

12.57 Patient Costs.

Any fee or expense for a Medically Necessary service incurred as a result of treatment provided to the Member for purposes of a clinical trial for the treatment of cancer. Patient Costs do not include the cost: (a) of any drug or device provided in a phase I or II cancer clinical trial; (b) of any Investigational drug or device; (c) of non-health services that might be required for a Member to receive treatment or intervention; (d) of managing the research of the clinical trial; and (e) that would not be Covered under the Plan**.**

12.58 Peer-Reviewed Medical Literature.

A phrase that is defined by two elements:

1. It refers to the requirement that medical literature on a topic is only considered relevant if it is a scientific study, which has been published in the English language (mostly American) only after review by academic experts for structure of study and validity of conclusions, prior to acceptance for publication; and

2. Based on a methodology used by certain authoritative bodies (including The National Cancer Institute PDQ Guidelines for Cancer Treatment and the International Consensus Conference on Bone Marrow Transplantation), the medical literature is graded for its quality using a 2-by-2 grid based on two parameters: **strength** of the evidence and **effectiveness**.

Strength of evidence is graded from the highest level of evidence to the lowest, as follows:

Level 1: Randomized, controlled trial

Level 2: Cohort/Case Control Study

Level 3: Systematic Literature Review

Level 4: Large consecutive case series

Level 5: Small consecutive case series

Level 6: Textbook chapters (opinion of a respected authority)

Level 7: Case report

Effectiveness is evaluated using 4 measurements:

1. Is the proposed treatment harmful or beneficial?
2. Do the results favor the study (Experimental) group or the control group?
3. Is the outcome considered statistically weak or strong?
4. Is the study design weak or strong?

12.59 Physician.

Any Doctor of Medicine (“M.D”) or Doctor of Osteopathy (“D.O.”), who is duly licensed and qualified under the law of the jurisdiction in which treatment is received.

12.60 Physician Services.

Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

12.61 PPACA

Patient Protection and Affordable Coverage Act of 2010, including any regulations promulgated thereunder.

12.62 Plan.

A benefit Plan that provides for Your health care services.

12.63 Preferred Pharmacy.

Those Participating Pharmacies that are identified as Preferred Pharmacies by Us. Please contact Our Customer Services Department for a list of Preferred Pharmacies.

12.64 Premium.

The amount that must be paid for Your Health Insurance or Plan. You usually pay it monthly, quarterly, or yearly.

12.65 Prescribing Provider.

Any person holding the degree of doctor of medicine, doctor of osteopathy, doctor of dental medicine or doctor of dental surgery or any other health care professional who is duly licensed in the state in which the Prescription Drug is prescribed to prescribe medications in the ordinary course of his or her professional practice.

12.66 Prescription Drug Coverage.

Health Insurance or Plan that helps pay for Prescription Drugs and medications.

12.67 Prescription Drugs.

A drug that:

- is provided for outpatient administration; and
    - has been approved by the Food and Drug Administration for a specific use; and
    - under federal or state law, can be dispensed only pursuant to a Prescription Order (legend drug); and
- has not been otherwise limited or Excluded under this Contract.

This definition includes some limited over-the-counter medications or disposable medical supplies (*e.g.*, insulin and diabetic supplies). It includes medications for treatment of certain types of cancer approved by the Federal Food and Drug Administration and proven effective and accepted for the treatment of a specific type of cancer in any one of the following established reference compendia:

- The American Medical Association Drug Evaluations;
- The American Hospital Formulary Service Drug Information; or
- The United States Pharmacopeia Drug Information.

A compound substance is considered a Prescription Drug if one or more of the items compounded is a Prescription Drug.

12.68 Prescription Order or Refill.

The Authorization for a Prescription Drug issued by a Prescribing Provider who is duly licensed to make such an Authorization in the ordinary course of his or her professional practice.

12.69 Primary Care Physician (PCP).

A Participating Provider who practices in the fields of Internal Medicine, Family Practice, General Practice, or Pediatrics who is designated as a Participating Provider by the Plan and who is responsible for providing care to Members or referring Members to other Providers in order to receive care. Note: Female members may also select a Woman's Principal Health Care Provider (WHPCP) in addition to their PCP. This physician specializes in women's health care needs and practices in the fields of Family Practice or Obstetrics and Gynecology.

12.70 Primary Care Provider.

A Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse Specialist or Physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services

12.71 Prior Authorization.

A decision by Us that a health care service, treatment plan, Prescription Drug or Durable Medical Equipment is Medically Necessary [or that any required referral was obtained from Your PCP]. Sometimes called Prior Authorization, prior approval, or precertification. We may require Prior Authorization for certain services before You receive them, except in an Emergency. Prior Authorization isn't a promise We will Cover the cost.

12.72 Provider or Provider Network.

A Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care Facility licensed, certified or accredited as required by state law**.**

12.73 Qualified Individual.

A Qualified Individual is an individual that the Health Insurance Marketplace has determined is eligible to enroll through the Health Insurance Marketplace in Our Plan, pursuant to the requirements of 45 C.F.R. § 156.155, which include individuals who either: (i) Have not attained the age of 30 prior to the first day of the Contract year or (ii) have received a certificate of exemption for the reasons identified in section 1302(e)(2)(B)(i) or (ii) of PPACA.

12.74 Reconstructive Surgery.

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

12.75 Rehabilitation Services.

Health care services that help a person keep get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational` therapy, speech-language pathology and psychiatric Rehabilitation Services in a variety of inpatient and/or outpatient settings.

12.76 Schedule of Benefits.

Your Schedule of Benefits lists the services available to You under the Contract, as well as the

Deductibles, Coinsurance, and Copayments associated with each service. There are other factors that impact how Your Coverage works and those are included in this Contract in the Exclusions & Limitations.

12.77 Service Area.

The geographic area served by CHL as approved by the Department of Human Resources and the Department of Insurance and shown in Section 13, in which CHL's health services are available and readily accessible to enrollees. CHL's Service Area is subject to change, and may not include all counties in the State of Tennessee.

12.78 Specialist.

A Physician Specialist focuses on a specific area of medicine to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has more training in a specific area of health care.

12.79 Specialty Drugs.

Defined by Us. Typically high-cost drugs, including but not limited to oral, topical, inhaled, inserted or implanted and injected routes of administration. These are identified in the Formulary with "SP" next to the name of the drug. Included characteristics of Specialty Drugs are that they:

(i) are used to treat and diagnose rare or complex diseases;

(ii) require close clinical monitoring and management;

(iii) frequently require special handling; and

(iv) may have limited access or distribution.

Specialty Drugs also include self-administered injectables, which are Prescription Drugs that, as defined by Us, are commonly and customarily administered by the Member and are Covered only when dispensed by the Specialty Pharmacy or other Pharmacy designated by Us. Examples of self-administered injectables include, but are not limited to, the following: multiple sclerosis agents, growth hormones, colony stimulating factors given more than once monthly, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain injectable HIV drugs, certain osteoporosis agents and heparin products. Note: For definition purposes, other injectable drugs that are acquired through the retail Pharmacy, injectable diabetes agents (such as insulin and glucagons), bee sting kits, Imitrex and injectable contraceptives are not considered to be self-administered injectables.

12.80 Specialty Pharmacy.

A pharmacy that has a Contract with Us and is designated by Us as a Specialty Pharmacy who provides certain Covered Drugs, including, but not limited to, Prescription Drugs and Specialty Drugs Orders or Refills.

12.81 Subscriber.

The eligible individual that has elected CHL Coverage for himself/ herself and/or any eligible Dependents through submission of an enrollment application and for whom or on whose behalf Premiums have been received by Us.

12.82 Urgent Care.

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Room Care.

If a condition requiring Urgent Care develops, You may go to the nearest Urgent Care Center, Participating Physician's office, or any other Provider for treatment. This treatment may be subject to a Copayment and/or Coinsurance. Examples of Urgent Care conditions include fractures, lacerations, or severe abdominal pain.

12.83 Value Formulary or Tier Zero Drugs.

Group of medications on the Formulary addendum, Value Formulary Tier Zero Drugs, that are available for a limited period of time at no Copayment to Members who meet the Plan criteria specified in the Formulary addendum.

12.84 We, Us, Our.

Coventry Health and Life Insurance Company

12.85 You / Your.

A Member Covered under this Contract.

SECTION 13
SERVICE AREA DESCRIPTION

The current Service Area consists of the following counties:

1. Fayette
2. Shelby
3. Tipton

State: Tennessee **Filing Company:** Coventry Health and Life Insurance Co.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs
Project Name/Number: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01

Rate Information

Rate data applies to filing.

Filing Method: SERFF
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: 0.000%
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Coventry Health and Life Insurance Co.	New Product	0.000%	0.000%	$0	0	$0	0.000%	0.000%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:								
Policy Holders:								

State: Tennessee **Filing Company:** Coventry Health and Life Insurance Co.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs
Project Name/Number: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01

Rate Review Detail

COMPANY:

Company Name: Coventry Health and Life Insurance Co.
HHS Issuer Id: 78575
Product Names:
TN CHL EXCHANGE Cov1 HPN PPO
Trend Factors: This is a new product.

FORMS:

New Policy Forms: TN CHL ON-EXCH. Cov1 HPN PPO -COC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.Pr.NC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver.Ind.Pr.NC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 1 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 2 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 3 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.Pr.NC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze.Ind.Pr.NC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Cat. -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –COC.Cat. -01.2014
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 0
Benefit Change: None
Percent Change Requested: Min: Max: Avg:

PRIOR RATE:

Total Earned Premium:
Total Incurred Claims:
Annual $: Min: Max: Avg:

REQUESTED RATE:

Projected Earned Premium: 3,500,000.00
Projected Incurred Claims: 2,700,000.00
Annual $: Min: 286.92 Max: 286.92 Avg: 286.92

SERFF Tracking #:	*CVLA-128995176*	***State Tracking #:***	*H-130560*	***Company Tracking #:***	*042013 - 01*

State:	*Tennessee*	***Filing Company:***	*Coventry Health and Life Insurance Co.*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs*		
Project Name/Number:	*TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01*		

Rate/Rule Schedule

SERFF Tracking #:	*CVLA-128995176*	***State Tracking #:***	*H-130560*	***Company Tracking #:***	*042013 - 01*

State:	*Tennessee*	***Filing Company:***	*Coventry Health and Life Insurance Co.*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs*		
Project Name/Number:	*TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01*		

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments

SERFF Tracking #: CVLA-128995176 **State Tracking #:** H-130560 **Company Tracking #:** 042013 - 01

State: Tennessee **Filing Company:** Coventry Health and Life Insurance Co.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs
Project Name/Number: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01

1		TN EXCH. Cov1 HPN PPO -- CHC-TN Individual Rate Manual 2014 (On Exchange)	TN CHL ON-EXCH. Cov1 HPN PPO -COC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.Pr.NC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver.Ind.Pr.NC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 1 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 2 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 3 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.Pr.NC -01.2014, TN CHL ON-EXCH.	New		2013 - 4.26.13 - recd. fr.Erik A. - CHC-TN Individual Rate Manual 2014 (On Exchange).pdf,

			Cov1 HPN PPO –SOB.2nd.Bronze -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze.Ind.NCS - 01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze.Ind.Pr.NC - 01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Cat. - 01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –COC.Cat. - 01.2014			

State: Tennessee **Filing Company:** Coventry Health and Life Insurance Co.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs
Project Name/Number: TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01

2		TN EXCH. Cov1 HPN PPO -- Memo Certification	TN CHL ON-EXCH. Cov1 HPN PPO -COC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.Pr.NC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver.Ind.Pr.NC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 1 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 2 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 3 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.Pr.NC -01.2014, TN CHL ON-EXCH.	New		4.29.13 - recd. fr.Erik A. - Memo Certification.pdf,

			Cov1 HPN PPO –SOB.2nd.Bronze -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze.Ind.NCS - 01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze.Ind.Pr.NC - 01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Cat. - 01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –COC.Cat. - 01.2014			

3		TN EXCH. Cov1 HPN PPO -- TN 2014 Actuarial Memo - FINAL	TN CHL ON-EXCH. Cov1 HPN PPO -COC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.Pr.NC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver.Ind.Pr.NC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 1 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 2 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 3 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.Pr.NC -01.2014, TN CHL ON-EXCH.	New		4.29.13 - recd. fr.Erik A. -- TN 2014 Actuarial Memo - FINAL.pdf,

			Cov1 HPN PPO –SOB.2nd.Bronze -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze.Ind.NCS - 01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze.Ind.Pr.NC - 01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Cat. - 01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –COC.Cat. - 01.2014			

4		TN EXCH. Cov1 HPN PPO -- Part III Actuarial Memorandum	TN CHL ON-EXCH. Cov1 HPN PPO -COC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.Pr.NC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver.Ind.Pr.NC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 1 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 2 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 3 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.Pr.NC -01.2014, TN CHL ON-EXCH.	New		4.29.13 - fr.SHARE DR.-TN2014URRTPartIIIMemoFINAL.pdf,

			Cov1 HPN PPO –SOB.2nd.Bronze -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze.Ind.NCS - 01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze.Ind.Pr.NC - 01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Cat. - 01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –COC.Cat. - 01.2014			

5		TN EXCH. Cov1 HPN PPO -- Unified Rate Review Template	TN CHL ON-EXCH. Cov1 HPN PPO -COC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Gold.Ind.Pr.NC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver.Ind.Pr.NC -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 1 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 2 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Silver 3 -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.NCS -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Bronze.Ind.Pr.NC -01.2014, TN CHL ON-EXCH.	New		4.30.13 -fr.SHARE DR-TN plan mgt 20130426wOFF v2 No Links--Wksh2-Pl.Prod.Info.pdf, 4.30.13 -fr.SHARE DR-TN plan mgt 20130426wOFF v2 No Links--Wksh1-Mkt exp.pdf,

			Cov1 HPN PPO –SOB.2nd.Bronze -01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze.Ind.NCS - 01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.2nd.Bronze.Ind.Pr.NC - 01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –SOB.Cat. - 01.2014, TN CHL ON-EXCH. Cov1 HPN PPO –COC.Cat. - 01.2014			

Company: **Coventry Health & Life Insurance Company, TN - Individual Exchange Products**
Forms: PPO Plans - TN CHL ON-EXCH. Cov1 HPN PPO
Effective: **Rate Manual Effective 1/1/2014**

Plan ID	Plan Name	Base Rate	Areas to sell	Service Area ID	Service Area Name
78575TN0340001	Gold $5 Copay HMO Baptist	$234.99	6	TNS001	Baptist HPN
78575TN0350001	Silver $10 Copay HMO Baptist	$212.53	6	TNS001	Baptist HPN
78575TN0360001	Bronze $10 Copay HMO Baptist	$163.17	6	TNS001	Baptist HPN
78575TN0360002	Bronze Deductible Only HMO HSA Eligible Baptist	$150.75	6	TNS001	Baptist HPN
78575TN0370001	Catastrophic 100% HMO Baptist	$92.22	6	TNS001	Baptist HPN

Area Number	Area Name	Factor
6	Greater Memphis	1.000

Tobacco	Factor
TN	1.20

Age	Factor
0-20	0.635
21	1.000
22	1.000
23	1.000
24	1.000
25	1.004
26	1.024
27	1.048
28	1.087
29	1.119
30	1.135
31	1.159
32	1.183
33	1.198
34	1.214
35	1.222
36	1.230
37	1.238
38	1.246
39	1.262
40	1.278
41	1.302
42	1.325
43	1.357
44	1.397
45	1.444
46	1.500
47	1.563
48	1.635
49	1.706
50	1.786
51	1.865
52	1.952
53	2.040
54	2.135
55	2.230
56	2.333
57	2.437
58	2.548
59	2.603
60	2.714
61	2.810
62	2.873
63	2.952
64	3.000
65 and over	3.000

0780-1-20-.02 ACTUARIAL MEMORANDUM.

Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called "anticipated loss ratio," of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Each rate submission must also include a certification by a qualified actuary.

Please have the actuary preparing this document sign the certification below. This must be an actual signature, not computer generated or rubber stamped.

I certify that to the best of my knowledge and judgment the rate filing is in compliance with the applicable laws and regulations of this state and that the benefits are reasonable in relation to premiums.

Signature Erik Axelsen

Print name Erik Axelsen

Title Actuarial Manager

Coventry Health & Life Insurance Company (CH&L TN)
CoventryOne Individual PPO Accident and Sickness Insurance Policies

Actuarial Memorandum

Submitted for your review and approval are proposed premium rates for Coventry Health & Life Insurance Company ("CH&L TN") new CoventryOne PPO product offering. This filing is being submitted to meet Tennessee rate filing requirements pursuant to Tennessee Code 0780-1-20. The purpose of this filing is to provide the Bureau with the proposed rates for the above products; this information may not be appropriate for other purposes.

(1) Rate Development and Assumptions

Rates were developed consistent with the experience period data and projection assumptions described in the attached "2014 Unified Rate Review Template Part III Actuarial Memorandum."

(2) Anticipated Loss Ratio

Under the current pricing assumption, the average MLR, as defined by PPACA, is projected to be 83.8% assuming 7.7% adjustment for taxes plus an additional 1% for federal and state taxes.

(3) Certification

I, Erik Michael Axelsen, am an Actuarial Manager for Coventry Health & Life Insurance Company and am issuing this opinion on behalf of CH&L TN, a wholly owned subsidiary. I am a member of the American Academy of Actuaries and an Associate of the Society of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. I hereby certify that to the best of my knowledge and judgment, the rates for the CoventryOne Individual Policies addressed within this memorandum are each reasonable in relation to the benefit provided. In addition, I certify that to the best of my knowledge and judgment, this filing is in compliance with the applicable laws and regulations of the state of Tennessee.

4/29/2013
_____
Date

//Erik Michael Axelsen
_____
Erik Michael Axelsen, ASA, MAAA
Manager, Actuarial
Coventry Health Care, Inc.

2014 Unified Rate Review Template
Part III Actuarial Memorandum

Company Legal Name:	**Coventry Health and Life Insurance Company**
State:	**Tennessee**
HIOS Issuer ID:	**78575**
Market:	**Individual PPO Rate Filing**
Effective Date:	**01/01/2014 through 12/31/2014**

Primary Contact Name:	**Erik Axelsen**
Telephone Number:	**678-742-6544**
Email Address:	**emaxelsen@cvty.com**

1. Scope and Purpose:

The purpose of this actuarial memorandum is to support the development of the Part I Unified Rate Review Template. CH&L TN intends to use the following rate development for individual business within its Tennessee service area effective 1/1/2014 through 12/31/2014 for the following forms:

Baptist HPN – TN CHL ON-EXCH.Cov1 HPN PPO

This memorandum is not intended to be used for any other purpose.

2. Summary of Changes

Not applicable. This is the initial offering of these products. Current plans with existing membership will be retired in 2014 and members will be given the option to move to new essential health benefit (EHB) compliant plans.

A. Proposed Rate Increases

Not applicable. This is the initial offering of these products.

B. Reasons for Rate Increase

Not applicable.

3. Experience Period Data

A. Experience Period

The base period experience is CH&L TN individual and small group incurred claims for calendar year 2012, paid through February 2013.

B. Earned Premium

Individual earned premium for the block was $2.0 M in the experience period, before any adjustments prescribed when calculating the MLR rebates, such as taxes and assessments. The 2012 MLR rebate is $0.0 M, as reported on the 2012 Supplemental Health Care Exhibit, resulting in total earned premium, net of rebates, of $2.0 M on Worksheet I, Section I.

C. Allowed Incurred Claims

The following table reports incurred claims for the individual experience that makes up the base period:

	Allowed	Incurred
Coventry Claim System	$ 1.8M	$ 1.2M
External Vendor Claim System	$ 0.4M	$ 0.3M
IBNR	$ 0.2M	$ 0.1M
Total	**$ 2.4M**	**$ 1.5M**

Allowed claims come directly from the CHC-TN claim records for hospital and physician services. Capitated benefits, including pharmacy, use the capitation rate for incurred claims and the allowed claims are calculated as the incurred claims plus estimated cost sharing.

D. Incurred But Not Paid

The same process is used for developing incurred but not paid estimates for both paid and allowed claims. Paid and allowed claims are adjusted for incurred but not paid completion factors.

Historical experience of claims is used to develop the medical claims reserve (commonly known as "IBNR"), a reserve for all medical claim amounts incurred but not yet reported and incurred, reported but not yet paid. More specifically, historical claims payment patterns are used to predict each month's ultimate incurred claims from paid claims. IBNR estimates are developed using actuarial principles and assumptions that consider, among other things, contractual requirements, historical utilization trends and payment patterns, benefits changes, medical inflation, product mix, seasonality, membership and other relevant factors including a review of large claims.

The completion factors are developed using the historical claims costs for the same block of business underlying the base period experience from Worksheet 1, Section 1.

4. Benefit Categories

Claim tagging is used to fit all fee-for-service medical claims into four categories: Hospital Inpatient, Hospital Outpatient, Physician Services, and Other Medical. Other medical services are an estimated portion of Hospital Outpatient claims including ambulance services, durable medical equipment, and prosthetics. The utilization for these services are counted by service type and rolled up into one utilization number for the total category. Inpatient utilization is counted as days; outpatient and other medical utilization is counted as services; and physician utilization is counted as visits. Capitated services are paid on a per member per month (PMPM) basis and have no utilization values attached. Although pharmacy is also capitated, the experience utilization by prescriptions is included.

5. Projection Factors

A. Change in the Morbidity of the Population Insured

Effective January 1, 2014, all policies issued in the individual and small group market are subject to new rating rules, including guaranteed issue and no medical underwriting. In addition, subsidies will be available to many individuals and families who are currently uninsured. The change in the morbidity of the future insured population relative to the current population in the experience period is based on changes in underwriting and rating factors, as well as expected sources of market expansion (including Medicare, Medicaid, individual insurance, small group employer insurance, large group employer insurance, the high risk pool).

Several sources, including the US Census Bureau, Kaiser Family Foundation, Medical Expenditure Panel Survey (MEPS), and Society of Actuaries studies (including "Design and Implementation Considerations of ACA Risk Mitigation Programs", and "Cost of the Future newly Insured under the Affordable Care Act (ACA)") were leveraged to develop the expected costs of each cohort and the expected migration in 2014.

B. Changes in Benefits

The new products include additional benefits to bring them into compliance with Tennessee Essential Health Benefits (EHBs). The benefit changes determined to have an impact on rates include the following:

Individual:

- Maternity: Maternity costs in the current Small Group employer market were compared to maternity costs in the current individual market. The anticipated increase is $6.44 PMPM.
- Habilitative Services: Actual data was used from states that currently cover these services. The anticipated price was estimated at 0.5% (~$1.33 PMPM) of premium.
- Other changes: All other EHBs were valued at $5.83 PMPM

The estimated net allowed impact of these changes relative to the current individual base period experience is $13.60 PMPM.

Benefit plans offered by CH&L TN on the exchange will not include coverage for pediatric dental. On the exchange, pediatric dental benefits will be available via stand alone plans. In order to comply with Tennessee Essential Health Benefits, members choosing to purchase coverage outside of the exchange will be required to have pediatric dental covered as part of their benefits. These members that have not purchased this benefit on a stand-alone basis on the exchange will have pediatric dental added to the medical plan through a mandatory rider at a cost of $3.00 PMPM.

The impact on utilization trend due to changes in benefits is described below under trend factors.

C. Changes in Demographics

The overall change in the morbidity of the population insured (as described in 5.A above) inherently includes changes in the demographics of the underlying population; a portion of the morbidity change above has been allocated to the demographic adjustment.

D. Other Adjustments

a. **[Network Impact** – Coventry developed specific networks for 2014 products in order to improve the affordability of health care coverage for our members. The impact of network changes includes changes to existing provider contract rates for 2014 products and steerage to low cost providers based on benefit design. The change in networks varies by plan design. Network savings specific to certain plan designs (i.e. Coventry's HPN model noted in section 1 above) are included in the Pricing Actuarial Value on Worksheet 2 on a revenue neutral basis. Overall network savings (averaged using Worksheet 2 projection by product) are estimated to decrease claims by 11.9% for combined Medical and Pharmacy claims.

   In addition, our pharmacy vendor estimates savings of 11.8% due to changes in the preferred pharmacy network formulary, and select home delivery.

b. Area Impact – The distribution of members by rating region (a.k.a. area) will differ in 2014 compared to the distribution reflected in the experience period. A few items impact the change in distribution: changes in the required rating region definitions that change

our expected relative competitive position, changes in the product offerings by region, and expected market expansion for the uninsured as noted in 5.A. above. The change in membership distribution by rating region will result in a decrease in expected claim cost of 0.7%.

E. Trend Factors

Anticipated annual trend from the experience period to the rating period for the product line is as follows:

Component	Unit Cost	Utilization	Benefit Changes Utilization	Total Trend
Medical	3.13%	5.75%	4.25%	**13.69%**
*Pharmacy	-2.73%	4.69%	4.25%	**6.16%**
Total	2.26%	5.59%	4.25%	**12.57%**

* Rx Unit Cost change set to 1.0 on Worksheet 1 to avoid submission errors.
Total Rx trend was loaded into the Rx Utilization component

a. Medical Trend

Allowed medical trend includes known and anticipated changes in provider contract rates, severity and medical technology impacts, and expected changes in utilization. The impact of benefit leveraging is accounted for separately in the projected paid to allowed ratio. The trends noted in the table above are for our current full network prior to any cost savings associated with network changes as shown in Other Trend above.

The change in projected utilization trend due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that will start in 2014. The federal risk adjustment program factors are an appropriate source to account for the expected change in utilization associated with changes in benefits. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived from the federal risk adjustment program factors.

b. Pharmacy Trend

Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend. The trends noted in the table above are for our current pharmacy network and current formulary. Changes to the current network and formulary are included in the Other Trend as noted above.

6. Credibility/Manual Rate

A. Manual rate

The source data for the manual rate is the CH&L TN and CH&L MS small group experience. Small group experience is an appropriate source for the manual rate because of the similarities in covered benefits, guaranteed issue and adjusted community rating requirements between CH&L TN & CH&L MS's current small group population and the projected 2014 individual market population.

The small group experience used as the basis for the manual rate was adjusted in a similar manner as the base period individual experience for changes in population risk, benefit design, demographic,

network, and rating regions. With the exception of Pediatric Vision, capitated benefits that will occur in the projection period also occurred in the base period individual experience and the small group experience for the manual rate. Pediatric Vision was considered in the change in benefits section.

B. Credibility

As noted in the Manual Rate section, the manual rate is developed using CH&L TN and CH&L MS small group experience. This block of business includes 57,298 member months during the experience period and is considered fully credible.

Given the strict underwriting applied in the individual market in Tennessee, CH&L TN's individual block was not considered in the manual rate and was given no credibility. The manual rate is given 100% credibility and the CH&L TN experience from Worksheet 1 is given 0% credibility.

7. Paid to Allowed

The projected paid to allowed ratio in the projection is based on the projection of members by benefit plan on Worksheet 2. Assuming the migration in Section 14, the paid to allowed ratio is approximately 68.0% in the 2014 projection.

8. Risk Adjustment and Reinsurance

A. Projected Risk Adjustment PMPM

Since the products were developed to be an attractive option across the entire spectrum of risk, the risk adjustment PMPM is expected to be $0.

B. Projected ACA Reinsurance Recoveries (Net of Reinsurance Premium)

ACA Reinsurance is considered an additional $5.26 PMPM cost to the health plan. The expected recoverable is estimated at $28.93 PMPM; for a net impact of ($23.67).

In order to estimate reinsurance program recoveries, analysis was done using medical and pharmacy claims incurred and discharged between November 2011- October 2012, paid through February 2013, which was then trended to 2014. The population that generated these claims is expected to have a morbidity profile similar to what we will see in the Individual market in 2014. Claims were aggregated for each member across the 12 month experience period. The 2014 reinsurance payment parameters ($60k threshold, 80% coinsurance, $250k cap) were applied to derive expected reinsurance payments.

Using a consistent multiplicative factor for reinsurance impact across all products would have led to inaccurate product pricing because large claim liabilities are not expected to materially fluctuate by product given the relatively small contribution of member cost-sharing on large claims, and because the $5.26 premium is assessed on a per member basis regardless of product. A consistent PMPM was used across all products in order to price appropriately for the reinsurance program impact.

9. Non-Benefit Expenses and Profit and Risk

A. Administrative Expense Load

The methodology used to determine the appropriate administrative expense PMPM for this product line involved forecasting 2014 administrative expenses and membership nationally.

Administrative expense dollars were forecast for 2014 based on 2013 administrative costs for fixed and variable expenses. Variable administrative expenses are projected as a PMPM and therefore the overall dollars grow with membership. Fixed costs include the projected costs for 'corporate

overhead' which are shared company services, including the cost for additional IT and Customer service expenses to support membership growth and exchange connectivity. Corporate overhead was allocated to the product lines based on a blending of the expected membership by market and the projected level of premium.

The projected administrative expense not including commissions is 10.7% of premium. The percent of premium load does not vary by product.

B. Commissions

Commissions are estimated to be equal to 2.15% of premium.

C. Profit and Risk Margin

The target gain/loss for this product is 3% of premium. The target does not vary by product.

D. Taxes and Fees

Taxes and fees include only the amounts eligible to be subtracted from premiums for the purposes of calculating MLR rebates They are as follows:

State Premium Tax	2.0%
Insurer Tax	2.5%
PCORI	0.06%
Exchange User Fees	3.15%
Total	**6.7%**

The reinsurance charge of $5.26 PMPM is not included in the amounts listed above despite its treatment as a claim, in the MLR calculations.

The exchange user fee is based on blending 3.5% for on exchange members and 0% for off exchange members, assuming 90% of the fully insured individual membership choose coverage on the exchange.

10. Projected Loss Ratio

Under the current pricing assumption, the average MLR, as defined by PPACA, is projected to be 83.8%.

11. Index Rate

A. Experience Period Index Rate

The index rate in the experience period is based on the CH&L TN allowed claims experience PMPM. All benefits within the experience period are assumed to be EHBs, therefore no allowed claims from the experience period were removed.

B. Projection Period Index Rate

The projected 2014 index rate is projected in accordance with federal regulations, normalized for the allowable modifiers which include member age (including child cap), tobacco use status and rating factors for each geographic region. The index rate is also adjusted for the EHBs that were not a covered benefit during the experience period.

Coventry developed an adjustment relative to the single risk pool to reflect the healthier and younger population we anticipate to enroll in the catastrophic plans, based on eligibility requirements. Because the catastrophic plan is handled separately in terms of the risk adjuster mechanism, it is appropriate to reflect this in the pricing. We assumed the majority of enrollees will be under 30 years old.

C. Plan Level Rate Development

The plan level rates are developed from the projected index rate in the following manner. First, the market wide adjustments are applied to the projected index rate to reflect expected reinsurance recoveries (net of reinsurance premium) and exchange user fees. Second, the market wide adjusted index rate is adjusted for the pricing actuarial value, area factor, expenses and profit, and the eligibility impact for catastrophic plans (if applicable) to arrive at the plan level rate for a given metal tier product. Note that the base index rate represents the cost of 100% Actuarial Value (no cost share) benefit coverage.

In order to develop a member-specific rate the plan level rate for a given metal tier product must have the applicable age factor, area factor, and tobacco load applied.

12. AV Metal Values

The AV Metal Values on Worksheet 2 were based on the AV calculator. There were adjustments made to reflect benefit features not handled by the AV calculator. Attached is the certification required by 45 CFR Part 156, §156.135.

Adjustments made to plan design entry within the AV Calculator (Certification Option 1)

- Different pharmacy copays for preferred pharmacies, non-preferred pharmacies and mail order. Copays entered into the AV calculator as a weighted average of the copays across pharmacy types.
- Tier 1A (preferred generics). Subclass of generic drugs for which we collect a lower copay than other generics. Copays entered into AV calculator for generic drugs as a weighted average of preferred generics and other Tier 1 drugs.
- Tiers 4 and 5 (preferred and non-preferred specialty drugs). Pharmacy coinsurance for specialty drugs entered into AV calculator as a weighted average of Tiers 4 and 5.
- Outpatient surgery copays. Copay was converted to an equivalent coinsurance and entered into the AV calculator as such.
- Advanced Imaging subject to coinsurance and copays. Copay was converted to equivalent coinsurance and the combined equivalent coinsurance amount was entered into the AV calculator.

Calculations made outside the AV Calculator for plan design impact (Certification Option 2)

- Specialist office visits not subject to deductible. Used continuance table for specialist office visits to determine the percent of visits that would not be subject to deductible and adjusted overall impact of deductible to account for that difference. An out-of-model adjustment was made to the AV calculation to account for this plan design feature.
- ER visits not subject to deductible. Used continuance table for ER visits to determine the percent of visits that would not be subject to deductible and adjusted overall impact of deductible to account for that difference. An out-of-model adjustment was made to the AV calculation to account for this plan design feature.
- Different cost-sharing for X-Ray and lab services by place of service. Used Coventry data to calculate the percent of these services that are performed by place of service and adjusted overall member cost-share to account for that difference. An out-of-model adjustment was made to the AV calculation to account for this plan design feature.

13. AV Pricing Values

The Actuarial Calculator produces Actuarial Values (AVs) that reflect the portion of costs that will be paid by the carrier versus the member, on average. The AV Pricing Value includes the following allowable, plan level adjustments to the index rate:

- Paid to allowed ratio for the plan
- Plan Specific Network Discounts
- Administrative Costs
- Commission / Distribution Costs
- Additional Plan Benefits Above the EHBs
- Eligibility Impact for Catastrophic Plans

The allowable plan level adjustments were applied to the index rate to develop plan level rates for each benefit plan. The AV pricing values were then calculated by comparing the relationship of the plan level premiums to a fixed reference plan level premium. The fixed reference plan was the Silver plan.

The utilization adjustments within the federal risk adjuster methodology are used to estimate utilization differences by metal tier (assuming a Bronze plan is the base, Silver will have 3% additional utilization and Gold will have 8% additional utilization). The federal risk adjustment program factors are assumed to be an appropriate source to account for the expected change in utilization associated with changes in benefits.

The eligibility impact for the catastrophic plans is described in Section 11.B.

14. Membership Projections

Projected membership is assumed to come from the following sources of potential members: currently insured individual and small group members, the uninsured, current Medicaid members and high risk pool members. Since there is no grandfathered business, all existing Coventry members will lose their existing coverage at renewal and will be purchasing new coverage (either with Coventry or a competitor). Net overall growth across the company is expected in all markets, but each state's membership change is subject to a number of variables including competitor premiums and product choices in each rating region. The projected membership shown for 2014 reflects this general uncertainty about market and region-specific growth.

15. Terminated Products

All products with existing membership in 2013 will be retired in 2014. Members currently on these products will be allowed to remain on the products until their contract period expires in 2014, at that point these members will be provided the opportunity to enter the exchange or move to a Coventry off exchange EHB product.

16. Plan type

Not applicable. The plan types in the drop down boxes on Worksheet 2 adequately identify the products in the projection period.

17. Warning Alerts

The warning in cell A82 on "Wksh 2 – Plan Product Info" appears because there is a 2% threshold of accuracy in cells A80 and A81 that does not appear in A82. Total premium from cell F82 is within 0.1% of the "Wksh 1 – Market Experience" total premium.

The warning in cell A99 on "Wksh 2 – Plan Product Info" appears because cell B99 and cell F99 are comparing allowed claims before reinsurance (B99) vs allowed claims reduced for reinsurance (F99). If the data supporting F99 is made consistent with B99, then a warning will appear in A86. It requires the "Total Allowed Claims" to be net of reinsurance.

18. Effective Rate Review Information (optional)

No applicable.

19. Reliance On Others

Although I have reviewed them for reasonableness, the following assumptions were developed by others. I have not reviewed the methodology in detail due to the substantial amount of additional time required and therefore have relied upon the expertise of the individuals in the attached reliance statements.

- Actuarial Value And Modifications
- Capitation Cost
- Value of Network Arrangements e.g. contractual changes with providers

20. Actuarial Certification:

I, Erik Michael Axelsen, am an actuary of Coventry Health Care, Inc., of which CH&L TN is a wholly owned subsidiary. I am a member of the American Academy of Actuaries and I meet the Academy qualification standards for rendering opinions of this type.

I hereby certify in my opinion, that:

This filing is in conformity with all applicable Actuarial Standards of Practice, including, but not limited to:

• ASOP No. 5, Incurred Health and Disability Claims
• ASOP No. 8, Regulatory Filings for Health Plan Entities
• ASOP No. 12, Risk Classification
• ASOP No. 23, Data Quality
• ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
• ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
• ASOP No. 41, Actuarial Communications.

- The projected index rate is:
    a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1))
    b. Developed in compliance with the applicable Actuarial Standards of Practice
    c. Reasonable in relation to the benefits provided and the population anticipated to be covered
    d. Neither excessive nor deficient

- The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

- The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

Qualification – The Part 1 Unified Rate Review Template does not demonstrate the process used by CH&L TN to develop rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans and for certification that the index rate is developed in accordance with federal regulation and used consistently and only adjusted by the allowable modifiers.

//Erik Michael Axelsen	4/24/2013
_____	_____
Erik Michael Axelsen, A.S.A., M.A.A.A.	Date

Actuarial Manager
Coventry Health Care, Inc.
Phone (678) 742-6544

2014 Unified Rate Review Template

Reliance Statement

I hereby affirm that the items checked below for the 2014 Unified Rate Review Template for HIOS Issuer ID **78575** were prepared under my direction and, to the best of my knowledge and belief, are accurate and complete. I also recognize that I am subject to maintaining documentation of the development of the selected assumptions and will provide satisfactory turnaround time if additional support is requested.

- Actuarial Value And Modifications _____
- Supplemental EHB pricing _____
- Projected Population Morbidity _____
- RX Cost and Utilization Trend ✓
- Administrative Fee _____
- Experience Period Rebate _____
- Impact of Reinsurance _____
- Value of Network Arrangements _____
- Medical Cost and Utilization Trend _____
- MHNet Capitation Rates ✓
- Dental Capitation Rates _____
- Other Capitation Rates _____

Nikki S. Jaunes

Signature

4/24/2013

Date

2014 Unified Rate Review Template

Reliance Statement

I hereby affirm that the items checked below for the 2014 Unified Rate Review Template for HIOS Issuer ID **78575** were prepared under my direction and, to the best of my knowledge and belief, are accurate and complete. I also recognize that I am subject to maintaining documentation of the development of the selected assumptions and will provide satisfactory turnaround time if additional support is requested.

- Actuarial Value And Modifications X
- Supplemental EHB pricing X
- Projected Population Morbidity ____
- RX Cost and Utilization Trend ____
- Administrative Fee ____
- Experience Period Rebate ____
- Impact of Reinsurance ____
- Value of Network Arrangements ____
- Medical Cost and Utilization Trend ____
- MHNet Capitation Rates ____
- Dental Capitation Rates ____
- Other Capitation Rates ____

Michael T McGinnis — Signature

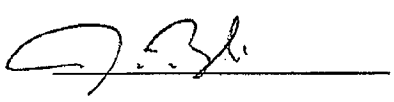
4/29/13 — Date

2014 Unified Rate Review Template

Reliance Statement

I hereby affirm that the items checked below for the 2014 Unified Rate Review Template for HIOS Issuer ID 78575 were prepared under my direction and, to the best of my knowledge and belief, are accurate and complete. I also recognize that I am subject to maintaining documentation of the development of the selected assumptions and will provide satisfactory turnaround time if additional support is requested.

- Actuarial Value And Modifications _____
- Supplemental EHB pricing _____
- Projected Population Morbidity _____
- RX Cost and Utilization Trend _____
- Administrative Fee _____
- Experience Period Rebate _____
- Impact of Reinsurance _____
- Value of Network Arrangements ✓
- Medical Cost and Utilization Trend _____
- MHNet Capitation Rates _____
- Dental Capitation Rates _____
- Other Capitation Rates _____



Signature

4/24/13

Date

Product-Plan Data Collection

Company Legal Name: Coventry Health and Life Insurance Company
HIOS Issuer ID: 78575
Effective Date of Rate Change(s): 1/1/2014

State: TN
Market: Individual

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product		Closed	th and Life Insurance Company - Indiv		th and Life Insurance Company - Indiv		Coventry Health and Life Insurance Company - Individual Products				th and Life Insurance Company - Indiv		Closed	Closed
Product ID:		78575TN031	78575TN034		78575TN035		78575TN036				78575TN037		78575TN032	78575TN033
Metal:		Catastrophic	Gold	Gold	Silver	Silver	Bronze	Bronze	Bronze	Bronze	Catastrophic	Catastrophic	Catastrophic	Catastrophic
AV Metal Value		0.550	0.783	0.783	0.699	0.699	0.620	0.582	0.620	0.582	0.550	0.550	0.550	0.550
AV Pricing Value		0.550	0.795	0.805	0.719	0.730	0.552	0.510	0.562	0.521	0.312	0.322	0.550	0.550
Plan Type:		PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
Plan Name		CLOSED	Gold $5 Copay HMO Baptist	OFF Gold $5 Copay HMO Baptist	Silver $10 Copay HMO Baptist	OFF Silver $10 Copay HMO Baptist	Bronze $10 Copay HMO Baptist	Deductible Only HMO HSA Eligible Baptist	OFF Bronze $10 Copay HMO Baptist	Deductible Only HMO HSA Eligible Baptist	Catastrophic 100% HMO Baptist	OFF Catastrophic 100% HMO Baptist	CLOSED	CLOSED
Plan ID (Standard Component ID):		78575TN0310001	78575TN0340001	78575TN0340002	78575TN0350001	78575TN0350002	78575TN0360001	78575TN0360002	78575TN0360003	78575TN0360004	78575TN0370001	78575TN0370002	78575TN0320001	78575TN0330001
Exchange Plan?		No	Yes	No	Yes	No	Yes	Yes	No	No	Yes	No	No	No
Historical Rate Increase - Calendar Year - 2		0.00%	0.00%		0.00%		0.00%				0.00%		0.00%	0.00%
Historical Rate Increase - Calendar Year - 1		0.00%	0.00%		0.00%		0.00%				0.00%		0.00%	0.00%
Historical Rate Increase - Calendar Year 0		0.00%	0.00%		0.00%		0.00%				0.00%		0.00%	0.00%
Effective Date of Proposed Rates		1/1/2012	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2012	1/1/2012
Rate Change % (over prior filing)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Proj'd Per Rate Change % (over Exper. Period)		-100.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %		#DIV/0!	0.00%		0.00%		0.00%				0.00%		#DIV/0!	#DIV/0!

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	78575TN0310001	78575TN0340001	78575TN0340002	78575TN0350001	78575TN0350002	78575TN0360001	78575TN0360002	78575TN0360003	78575TN0360004	78575TN0370001	78575TN0370002	78575TN0320001	78575TN0330001
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$286.98	$0.00	$335.44	$339.66	$303.37	$308.02	$232.91	$215.19	$237.13	$219.83	$131.65	$135.86	$0.00	$0.00
Projected Member Months	12,205	0	104	0	9,812	0	1,026	1,026	0	0	237	0	0	0

ction III: Experience Period Information

Plan ID (Standard Component ID):	Total	78575TN0310001	78575TN0340001	78575TN0340002	78575TN0350001	78575TN0350002	78575TN0360001	78575TN0360002	78575TN0360003	78575TN0360004	78575TN0370001	78575TN0370002	78575TN0320001	78575TN0330001
Average Rate PMPM	$161.20	$161.20												
Member Months	12,328	12,328												
Total Premium (TP)	$1,987,295	$1,987,295	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EHB basis or full portion of TP, [see instructions]	0.00%	0.00%												
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%												
Other benefits portion of TP	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Total Allowed Claims (TAC)	$2,392,848	$2,392,848												
EHB basis or full portion of TAC, [see instructions]	0.00%	0.00%												
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%												
Other benefits portion of TAC	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Allowed Claims which are not the issuer's obligation:	$858,169	$858,169	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0		$0		$0	$0	$0	$0			$0		$0	$0
Portion of above payable by HHS on behalf of insured person, as %	0.00%		#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!		#DIV/0!	#DIV/0!
Total Incurred claims, payable with issuer funds	$1,534,680	$1,534,680	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Net Amt of Rein	$0.00	$0.00												
Net Amt of Risk Adj	$0.00	$0.00												

Incurred Claims PMPM	$124.49	$124.49	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Allowed Claims PMPM	$194.10	$194.10	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
EHB portion of Allowed Claims, PMPM	$0.00	$0.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

ction IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	78575TN0310001	78575TN0340001	78575TN0340002	78575TN0350001	78575TN0350002	78575TN0360001	78575TN0360002	78575TN0360003	78575TN0360004	78575TN0370001	78575TN0370002	78575TN0320001	78575TN0330001
Average Rate PMPM	$286.98	$0.00	$335.44	$339.66	$303.37	$308.02	$232.91	$215.19	$237.13	$219.83	$131.65	$135.86	$0.00	$0.00
Member Months	12,205	-	104	-	9,812	-	1,026	1,026	-	-	237	-	-	-
Total Premium (TP)	$3,502,547	$0	$34,886	$0	$2,976,711	$0	$238,966	$220,784	$0	$0	$31,200	$0	$0	$0
EHB basis or full portion of TP, [see instructions]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Total Allowed Claims (TAC)	$4,104,706	$0	$34,977	$0	$3,299,908	$0	$345,058	$345,058	$0	$0	$79,706	$0	$0	$0
EHB basis or full portion of TAC, [see instructions]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Allowed Claims which are not the issuer's obligation	$1,424,953	$0	$8,243	$0	$1,078,715	$0	$142,401	$156,641	$0	$0	$38,953	$0	$0	$0
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0		$0		$0	$0	$0	$0			$0		$0	$0
behalf of insured person, as %	0.00%		0.00%		0.00%	#DIV/0!	0.00%	0.00%			0.00%		#DIV/0!	#DIV/0!

Total Incurred claims, payable with issuer funds	$2,679,753	$0	$26,734	$0	$2,221,194	$0	$202,657	$188,416	$0	$0	$40,753	$0	$0	$0
Net Amt of Rein	$353,091	$0	$3,009	$0	$283,861	$0	$29,682	$29,682	$0	$0	$6,856	$0	$0	$0
Net Amt of Risk Adj	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Data Collection Template

Company Legal Name: Coventry Health and Life Insu State: TN
HIOS Issuer ID: 78575 Market: Individual
Effective Date of Rate Change(s): 1/1/2014

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 1/1/2012 to 12/31/2012

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$1,987,295	$161.20	100.00%
Incurred Claims in Experience Period	$1,534,680	124.49	77.22%
Allowed Claims:	$2,392,848	194.10	120.41%
Index Rate of Experience Period		$194.10	
Experience Period Member Months	12,328		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/1/2014 to 12/31/2014 Mid-point to Mid-point, Experience to Projection: 24 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	Utilization Description	Utilization per 1,000	Average Cost/Service	PMPM	Pop'l risk Morbidity	Other	Cost	Util	Utilization per 1,000	Average Cost/Service	PMPM	Utilization per 1,000	Average Cost/Service	PMPM
Inpatient Hospital	days	89.71	$4,885.49	$36.52	1.224	1.192	1.049	1.100	132.86	$6,408.19	$70.95	241.26	$2,910.30	$58.51
Outpatient Hospital	services	471.06	1,059.66	41.60	1.224	1.192	1.050	1.130	736.23	1,392.58	85.44	961.73	1,093.88	87.67
Professional	services	15,405.64	60.45	77.61	1.224	1.192	1.006	1.084	22,157.45	72.92	134.65	24563.94	65.03	133.12
Other Medical	services	52.34	1,059.66	4.62	1.224	1.192	1.050	1.130	81.80	1,392.58	9.49	106.86	1,093.88	9.74
Capitation	0	12,000.00	4.77	4.77	1.000	1.000	1.115	1.000	12,000.00	5.93	5.93	12069.56	4.30	4.32
Prescription Drug	scripts	7,730.69	44.99	28.98	1.224	1.052	1.000	1.062	10,672.07	47.33	42.09	16238.36	53.12	71.88
Total				$194.10							$348.56			$365.24

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	0.00%	100.00%	$365.24	$4,457,797
Paid to Allowed Average Factor in Projection Period			0.680	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$248.37	$3,031,302
Projected Risk Adjustments PMPM			0.00	0
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$248.37	$3,031,302
Projected ACA reinsurance recoveries, net of rein prem, PMPM			28.93	353,091
Projected Incurred Claims			$219.44	$2,678,211
Administrative Expense Load		12.81%	36.75	448,586
Profit & Risk Load		3.00%	8.61	105,055
Taxes & Fees		7.71%	22.12	269,992
Single Risk Pool Gross Premium Avg. Rate, PMPM			$286.92	$3,501,845
Index Rate for Projection Period			$295.59	
% increase over Experience Period			77.99%	
% Increase, annualized:			33.41%	
Projected Member Months				12,205

Supporting Document Schedules

Bypassed - Item:	Accident & Health - Individual New Rates
Bypass Reason:	All rate information has been submitted under the Rate/Rule Schedule.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Memorandum A & H Certification - Individual
Bypass Reason:	All rate information has been submitted under the Rate/Rule Schedule.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Cover Letter Accident & Health
Bypass Reason:	All pertinent information is included in the filing description, including the primary form number and NAIC number.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Description of Variables
Comments:	Attached is the Statement of Variability for the documents submitted with this filing.
Attachment(s):	TN STMENT. of VAR.- 4.26.13 - CHL-TN EXCH. Cov1 HPN PPO--COC and SOBs -01.2014.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Filing Fees
Comments:	Attached is the completed Tennessee Filing Fee Form.
Attachment(s):	TN FILING FEE FORM --4.27.13-- CHL-TN EXCH. Cov1 HPN PPO--COC and SOBs -01.2014.pdf
Item Status:	
Status Date:	

SERFF Tracking #:	*CVLA-128995176*	***State Tracking #:***	*H-130560*	***Company Tracking #:***	*042013 - 01*

State:	*Tennessee*	***Filing Company:***	*Coventry Health and Life Insurance Co.*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs*		
Project Name/Number:	*TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01*		

Satisfied - Item:	PPACA Uniform Compliance Summary
Comments:	Attached is the PPACA Uniform Compliance Summary for the CHL-TN EXCHANGE Cov1 HPN PPO product.
Attachment(s):	TN PPACA COMPL.SUMM --4.29.13-- CHL-TN EXCH.Cov1 HPN PPO--COCs-SOBs.01.2014.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Third Party Authorization
Bypass Reason:	This filing is being made on behalf of Coventry Health and Life Insurance Company with no third party involvement.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Readability Certification
Bypass Reason:	Coventry is working on meeting the readability certification requirements for this product.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	This is a new product submission.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Memorandum and Certifications
Bypass Reason:	All rate information has been submitted under the Rate/Rule Schedule.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Unified Rate Review Template
Bypass Reason:	All rate information has been submitted under the Rate/Rule Schedule.

SERFF Tracking #:	*CVLA-128995176*	***State Tracking #:***	*H-130560*	***Company Tracking #:***	*042013 - 01*

State:	*Tennessee*	***Filing Company:***	*Coventry Health and Life Insurance Co.*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs*		
Project Name/Number:	*TN CHL EXCHANGE Cov1 HPN PPO - COC and SOBs/04192013 - 01*		

Attachment(s):	
Item Status:	
Status Date:	

Statement of Variability

We have created an application for Health Coverage to be used in the Tennessee Health Insurance Exchange. Items in the forms are bracketed for the following reasons:

Some items are bracketed as place holders to indicate variable items, such as an address or phone number. Once the document has been approved, the appropriate term will be inserted as indicated in the filed document. (Examples, see grid below, Section 1.10 :

For Customer Service Department and To Submit Claims	
Hours	Monday-Friday: [8:00 am to 6:00 pm EST]
Toll Free Telephone Number	**855-449-2889**
Address	[Coventry Health and Life Insurance Company P.O. Box 7813 London, KY 40742]
To Request a Review of Denied Claims or to Appeal a Denial of Authorization of Services	
Hours	Monday-Friday: [8:00 am to 6:00 pm EST]
Toll Free Telephone Number	**855-449-2889**
Address	**[**Coventry Health and Life Insurance Company 5350 Poplar Ave, Suite 390 Memphis, Tennessee 38119] Attn: Appeals Department
To Register a Complaint	
Hours	Monday-Friday: [8:00 am to 6:00 pm EST]
Toll Free Telephone Number	**855-449-2889**
Address	[Coventry Health and Life Insurance Company 5350 Poplar Ave, Suite 390 Memphis, Tennessee 38119] Attn: Quality Improvement Department

LIFE, ACCIDENT&HEALTH, CREDIT, VARIABLE FILING FEE FORM FOR TENNESSEE

_____ Domiciliary state does not have a filing fee.

__X__ Domiciliary state has a filing fee for filings of this type. Please submit a copy of a completed fee form and your check to the following address:

Actuarial Resources Section – Life & Health
Department of Commerce & Insurance
500 James Robertson Parkway
Nashville, TN 37243

Company __Coventry Health and Life Insurance Company_

Filing Fee __$900.00__

Check # #2256 ($850.00) and #2355 ($50.00)

SERFF Tracking Number _CVLA-128995176_

ACTUARY	Allotment Code	Cost Center	Revenue Code
20	**335.02**	**1000**	**122/552**

If you have any questions, please call 615-741-2825.

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☑ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☐ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Coventry Health and Life Insurance Company	81973	CVLA-128995176	TN CHL ON-EXCH. Cov1 HPN PPO -COC -01.2014 and associated documents	☑ Yes ☐ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
H16I Individual Health - Major Medical	**Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19**	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: We have no pre-existing condition exclusions for enrollees under age 19.			
	Page Number: N/A			
H16I Individual Health - Major Medical	**Eliminate Annual Dollar Limits on Essential Benefits** Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: We have no annual dollar limits on essential benefits.			
	Page Number: See benefits listed in Schedules of Benefits.			
H16I Individual Health - Major Medical	**Eliminate Lifetime Dollar Limits on Essential Benefits**	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☑ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: We have no annual lifetime dollar limits on essential benefits. We have no grandfathered plans.			
	Page Number: See benefits listed in Schedules of Benefits.			
H16I Individual Health - Major Medical	**Prohibit Rescissions –** Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☑ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain
	Explanation: We only allow rescission for fraud or intentional misrepresentation of material fact. We have no grand fathered plans.			
	Page Number: Section 3.1(B)(3) on pages 16-17 of the Certificate of Coverage.			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
H16I Individual Health - Major Medical	**Preventive Services –** Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: There is no cost sharing for In-Network preventive services.			
	Page Number: See benefits listed in Schedules of Benefits.			
H16I Individual Health - Major Medicall	**Extends Dependent Coverage for Children Until age 26 –** If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☑ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: We offer dependent coverage, including dependent coverage until age 26. We have no grandfathered plans.			
	Page Number: See Section 2.1.2 on page 14 of the Certificate of Coverage.			
H16I Individual Health - Major Medical	**Appeals Process –** Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: We have an internal claims appeal process and external review process.			
	Page Number: See Section 7 on pages 48-54 of the Certificate of Coverage.			
H16I Individual Health - Major Medical	**Emergency Services** – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no,** please explain.
	Explanation: We cover emergency services to provide such coverage without the need for prior authorization.			
	Page Number: See page 69 of the Certificate of Coverage.			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
H16I Individual Health - Major Medical	**Access to Pediatricians** – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Members are permitted to designate a physician who specializes in pediatrics as a child's PCP.			
	Page Number: See pages 6 and 69 of the Certificate of Coverage.			
H16I Individual Health - Major Medical	**Access to OB/GYNs** – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: We do not require authorization or referral for obstetrical or gynecological care provided by in-network providers.			
	Page Number: See pages 7 and 36 of the Certificate of Coverage.			

Reset Form

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			